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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE JOSEPH C. SPERO, MAGISTRATE JUDGE

DAVID AND NATASHA WIT, et al., Plaintiffs, VS. UNITED BEHAVIORAL HEALTH Defendant.	**No. C 14-2346 JCS**
GARY ALEXANDER, et al., Plaintiffs, VS. UNITED BEHAVIORAL HEALTH, Defendant.	**No. C 14-5337 JCS**
	San Francisco, California Monday, October 16, 2017

TRANSCRIPT OF PROCEEDINGS

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(Appearances continued on next page)

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P R O C E E D I N G S

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THE CLERK: We're calling Case Number C 14-2346, Wit versus UnitedHealthcare Insurance Company, and the related case C 14-5337, Alexander versus United Behavioral Health.

Appearances, please.

MS. REYNOLDS: Good morning, Your Honor. Caroline Reynolds from Zuckerman Spaeder on behalf of the plaintiffs and the plaintiffs class. And with me today are my colleagues, Aitan Goelman, Carl Kravitz, Adam Abelson; and our co-counsel, Meiram Bendat and Anthony Maul, are also with us in the courtroom today.

And I'd also like to introduce to the Court several of the named plaintiffs who have come to attend. David Haffner, Linda Tillitt, Brandt Pfeifer, and Gary.

THE COURT: Okay. Welcome, everyone.

And for the defense?

MS. ROMANO: Good morning, Your Honor. Jennifer Romano from Crowell Moring. With me are my colleagues Jeff Rutherford, Nathaniel Bualat, April Ross, and Andy Holmer.

We also have our client representative here. That's Dr. Andrew Martorana. He's the senior behavioral medical director.

And we have an in-house counsel here as well, Matthew

Shors. He's the senior deputy general counsel/chief litigation counsel for UnitedHealth Group.

THE COURT: Okay. Thank you all.

Are we doing openings?

MS. REYNOLDS: Yes, Your Honor.

THE COURT: Okay. I'll start with plaintiff.

MS. ROMANO: Your Honor, before we do openings, we had one housekeeping matter we wanted to take care of.

THE COURT: Okay.

MS. ROMANO: I raised this at the pretrial conference and after looking at the transcript wanted to clarify one thing.

The Court made clear at the pretrial conference that legal argument, such as causation issues, are preserved for appeal; but I wanted to just clarify and make clear on the record that while UBH and agrees and has agreed that the individualized clinical class member evidence is irrelevant for the class trial, that UBH continues to contend that it is relevant for class certification and decertification.

So we wanted to state on the record that the evidence presented in connection with the class certification motion continues to demonstrate class certification wasn't appropriate, and the fact that UBH will not attempt to offer such evidence at trial doesn't waive its arguments with respect to whether the class has been certified or should be

decertified; and that also UBH reserves the right to present this evidence as a basis for decertification and/or on appeal.

THE COURT: Okay.

MS. ROMANO: Thank you, Your Honor.

THE COURT: Thank you.

MR. ABELSON: One other housekeeping matter, if I may.

THE COURT: Yes.

MR. ABELSON: Adam Abelson on behalf of the plaintiffs.

THE COURT: Yes.

MR. ABELSON: This relates to the deposition designations. It's true housekeeping, but this came up briefly at the pretrial conference so --

THE COURT: This is true housekeeping.

MR. ABELSON: Yes.

THE COURT: This is like Windows.

MR. ABELSON: I didn't use the word "literally."

So we've cut the videos in terms of the depositions that the plaintiffs plan to play. Our portions total about seven hours. We're going to continue to try to cut those. UBH's counterdesignation portions are three hours, and we believe that that is -- it's unfair for those three hours, which essentially transfers three hours from us to them to testimony that they want in the case is not fair.

We have generate -- we've generated an output from the

software that does it. I don't think there's any dispute about what time -- how much time what they've added as opposed to what we've added, and we -- again, they have -- it's sort of like direct examination/cross-examination, which clearly goes back and forth.

And so to the extent there's -- I understand that we wouldn't want Ms. Hom or anybody else to be having to turn the timer on and off, but we have those numbers. We've done that administrative work.

I'd also like to add that UBH does have deposition designations in their case. We have counterdesignations to theirs. It's much shorter. So if this were to come out in the wash, if you will, that would be one thing, but it just doesn't. And so we're limited on time --

THE COURT: You think it's like an hour and a half unfairness instead of three hours of unfairness.

MR. ABELSON: Well, we haven't timed those, but I would guess it wouldn't be more than a half hour of our counterdesignations.

MR. HOLMER: Well, first of all, Your Honor, we received estimates from plaintiffs' counsel last night, the time estimates that Mr. Abelson referred to. We have not confirmed those, so we're not prepared to stipulate one way or the other about those; and partly we didn't confirm those because we understood the Court's ruling from the pretrial

conference to be that whatever -- I believe your words were, "Whatever you play, that's your time." So that's our understanding of the Court's ruling. We're okay with that. We understand. We made some revisions to our depo designations as well.

And part of this, I'd just like to point out, is that the time estimate that plaintiffs' counsel referred to of three hours includes roughly an hour of Dr. Bonfield's testimony, Dr. Bill Bonfield, who the parties have already agreed the time would be split.

And the reason for that, Your Honor, is that the parties both designated significant portions of Dr. Bonfield's testimony that overlapped, both in the actual testimony but also in the topics that were being covered. And so about an hour of the three-hour estimate that Mr. Abelson referenced comes from Dr. Bonfield, which the parties have already agreed will be split 50-50.

So I think that the estimate is a little bit off. We're talking about roughly two hours of testimony based on plaintiffs' estimate. Again, we haven't confirmed that.

But the larger point, I think, Your Honor, is that we think your ruling was correct. It would be a logistical nightmare for the Court for almost 20 depositions to continue to add and subtract time from the parties' timers.

We also think it's fair --

THE COURT: That's enough. Next.

I'm not changing my ruling. I'm not doing anything to encourage two things: One, more time in court. You've got more than enough time in court. You've got too much time in court.

And, two, playing of depo excerpts. Now that I've read a number of these depo excerpts, it is not in any of your clients' interests to try your case by doing depo excerpts because it's not -- because the problem is, in a bench trial, you have the judge there and the judge can say, "I didn't understand that. Could you explain that again?" In a depo I don't get to do that.

So it's a mistake if you have any alternative to put on a depo excerpt, but that's fine if you don't have any alternative. You should have taken a different kind of deposition because I can tell you that half of it's lost in the shuffle, but I'm certainly not going to encourage people to either play more of those or take more time in court. So I'm not going to change my ruling.

Next.

MR. HOLMER: Thank you, Your Honor.

THE COURT: Okay. Openings.

OPENING STATEMENT

MS. REYNOLDS: Good morning, Your Honor.

THE COURT: Good morning.

MS. REYNOLDS: Again, I'm Caroline Reynolds on behalf of the plaintiffs.

This case is about how an ERISA fiduciary, United Behavioral Health, developed fundamentally flawed clinical guidelines and then used those guidelines to deny the class members requests for coverage of their mental health and substance use disorder treatment.

UBH's guidelines contain significant deficiencies and in violation of the class members plans fall below generally accepted standards of care.

The guidelines purport to follow source material that's consistent with generally accepted standards; but when UBH didn't like what the source materials said, it simply edited the language to fit its overly restrictive, acute focused view of utilization management.

This underscores the fact that not only was UBH conflicted, its conflict was deep-seated and violated the obligation of an ERISA fiduciary to administer plans solely in the interests of the participants and beneficiaries.

The guidelines require that the member have an acute crisis and then call for coverage of the acute signs and symptoms at the prescribed level of care, but only if it is the least restrictive alternative and only until the acute changes are controlled or reduced. At that point, coverage ends.

Whether the prescribed level of care at the requested

duration is needed to address the member's ongoing illness or co-occurring conditions is not a basis for coverage under these guidelines.

The result compelled by these guidelines as they are written is that UBH will not approve coverage for the effective treatment of ongoing chronic conditions once an acute crisis has ended.

This is a major problem that makes these guidelines as a whole completely incompatible with generally accepted standards of care and, as a result, they're completely incompatible with the class members plans.

The documentary evidence, which plaintiffs will present through its summary witness, will show that the plans at issue all cover mental health and substance use disorder treatment. Generally speaking, the plans fall into two categories: Those that define coverage to extend only to treatment that is consistent with generally accepted standards of care, such as by defining "covered services" or "medically necessary treatment" to mean consistent with generally accepted standards; and, on the other hand, those that define "coverage" broadly to include mental health and substance use disorder treatment and then exclude services that are not consistent with generally accepted standards. This is just the flip side of the coin.

For every one of those plans, a precondition of coverage

is that the treatment must be consistent with generally accepted standards of care. This is not the same thing as saying that the plans provide coverage for all services that are consistent with generally accepted standards. That's not plaintiffs' argument.

The plans contain all sorts of limitations and exclusions and requirements that are just not part of this case. According to UBH's policies and procedures, the first step in evaluating any request for coverage is to make sure that none of those administrative requirements or limitations or exclusions applies.

If a member isn't eligible for coverage or if treatment for a particular condition is expressly excluded, UBH issues an administrative denial. Administrative denials are not made pursuant to UBH's clinical guidelines and are irrelevant to this case.

By definition, all of the denials at issue were clinical denials under the level of care guidelines or coverage determination guidelines, both of which purport to be based on generally accepted standards of care.

So, Your Honor, as you listen to UBH's arguments about alleged differences among the plans, please remember this: UBH analyzes requests for coverage under all of these plans pursuant to the same set of level of care criteria. This is powerful evidence that all of these plans contain the same

threshold requirement because UBH itself has already interpreted them that way.

The evidence will also show that UBH developed and used its guidelines to make clinical determinations about whether to approve the class member's request for coverage. The guidelines themselves tell us that UBH uses them for that purpose. The Level of Care Guidelines, for example, say that UBH's peer reviewers use the guidelines when making adverse medical necessity determinations.

Under UBH's accreditation standards and its own established policies and procedures, which plaintiffs will prove through UBH's own documents, UBH is required to cite a guideline when it issues a clinical coverage determination. And the evidence will show that in each one of the class members cases, UBH did base its denial on either the Level of Care Guidelines or a coverage determination guideline.

The evidence will also show that because of the exercise of discretion inherent in both of these discrete tasks, both developing the guidelines and using them to make clinical coverage determinations were fiduciary acts.

Let's talk about generally accepted standards of care for a moment. There are generally accepted standards of care for treating patients with mental illnesses and substance use disorders. There is no dispute on that, and there's really no dispute that there are generally accepted standards of care for

how to make level of care placement decisions for those patients.

In the behavioral health field, the treatment setting is an integral part of effective and appropriate treatment. As the evidence will reflect, there is a continuum of care for behavioral health treatment along which treatment could be provided in a number of different settings with different levels of service intensity within each setting.

At one end of the spectrum you have routine outpatient treatment. So, for example, a person may go to see a psychiatrist or psychologist in an office setting once a week for a period of time.

Slightly more intense level of services would be seeing the psychiatrist more frequently, two times a week or three times a week.

Some patients might require more intensive services, such as intensive outpatient treatment where they are in a treatment setting for several hours a day, several times a week.

Toward the other end of the spectrum, some patients may need to be immersed in a treatment setting for 24 hours a day in a residential treatment facility.

And then at the other end, patients who are an imminent danger to themselves or others need to be hospitalized until that imminent danger can be controlled. That's often called the acute inpatient level of care.

These levels of care provide very different treatment settings from one another. They address different needs, and for that reason selecting the appropriate level of care for a particular patient is a critical threshold decision that behavioral health providers make in every case.

Plaintiffs will offer the testimony of experts who were at the top of their respective fields, each of whom has evaluated UBH's Level of Care Guidelines and will explain to the Court why those guidelines fall below generally accepted standards. They each have deep knowledge of what the generally accepted standards of care are in their respective specialties, and each will testify that UBH's guidelines violated those standards because they were overly restrictive in their requirements for coverage.

As these experts will explain to the Court, it is a generally accepted standard of care in the behavioral health community to provide the most effective treatment for a person's mental health or substance use disorder.

In order to do that, it's also a generally accepted standard of care to make patient-centered decisions about level of care placement that are based on a thorough assessment and evaluation of a wide range of factors about the whole person.

As plaintiffs' experts will explain, one of the key factors to evaluate is whether the patient has co-occurring conditions; that is, multiple diagnoses, whether those are

behavioral health or medical diagnoses.

For example, a person might be diagnosed with depression or anxiety and a substance use disorder. This happens a lot. And when it happens, it's a generally accepted standard of care to provide effective treatment of the co-occurring condition as well.

It's generally accepted in the behavioral health community that some patients may require treatment to maintain their level of functioning or prevent deterioration, and it's generally accepted to provide that treatment.

And it's generally accepted in the behavioral health community that many behavioral health conditions are chronic and that it is appropriate to provide effective treatment throughout the course of a chronic illness.

There's really very little dispute among the parties' experts about those generally accepted standards. What the experts in this case vehemently disagree about is whether UBH's guidelines are consistent with those standards.

The evidence will show that UBH's guidelines fall far short of these standards and that UBH's evidence to the contrary does not withstand even modest scrutiny.

The guidelines fall far outside any reasonable interpretation of what is generally accepted, and let me turn now to the evidence of why that's true.

The evidence will show that UBH's guidelines are

pervasively biased in favor of restricting coverage. This shows up in the guidelines in several ways.

For one, the guidelines have an unrelenting focus on acute symptoms. This is evident throughout the class period whether UBH uses words like "presenting problems" or "'why now' factors" to refer to them.

The evidence will show that besides the guidelines single-minded focus on acute symptoms, they leave out other considerations that under generally accepted standards are essential to making appropriate patient placement decisions:

What's needed for the effective treatment of the patient's chronic conditions or their underlying illness?

What's needed to effectively treat any co-occurring conditions?

And what may be needed to address the special considerations applicable to children and adolescents?

I'm not going to attempt right now to walk through every word of every guideline, but I do want to hopefully quickly offer an overview of what is called the common criteria, which are the requirements that apply across the board to every diagnosis and at every level of care.

First I want to briefly explain the structure of UBH's Level of Care Guidelines using the year 2015 as an example. Exhibit 5 for identification is UBH's 2015 Level of Care Guidelines. In the Table of Contents, we can see that the

different sections that make up the guidelines include an introduction; some guiding principles; there are a few pages on development, approval, dissemination, and use; and then there's the section entitled "Common Criteria and Clinical Best Practices for All Levels of Care," which we'll discuss in a moment. Every request for coverage of any behavioral health service has to meet the common criteria.

Then there are sections on each of the specific levels of care. The Court will note that under the heading of "Mental Health" there are sections on each of the levels of care at issue in this case: Residential treatment, intensive outpatient treatment, and outpatient treatment.

And the Court will likewise note that under the heading of "Substance-Related Disorders," each of these levels of care also appear; and in the "Substance Use Disorder" section, residential treatment is referred to as residential rehabilitation. Each of those -- the criteria in each of those sections specify that the common criteria must be satisfied. So let's look at them.

The section starting on page 8 of Exhibit 5 contains two parts: The common criteria and the clinical best practices. The requirements in both sections have to be satisfied before UBH will approve coverage. The common criteria include admission, continued stay, and discharge criteria.

I'd first like to draw the Court's attention to what is

arguably the most important word in these criteria, "and." It's in all caps, underlined, and it appears between each and every one of the common criteria. There is no question what this means. Every one of these criteria has to be satisfied, not just Section 1.7.3, which says that services have to be consistent with Optum's Best Practice Guidelines. While it may be necessary for your doctor to use what UBH considers to be best practices, it certainly is not sufficient under these guidelines for UBH to approve coverage.

Nevertheless, despite the grammatical clarity, despite the all caps and underlining, the Court will watch and listen as some UBH witnesses in an attempt to defend these guidelines argue that "and" really means "or" so that the best practices section somehow makes the other criteria irrelevant, but that argument just does not line up with what these guidelines actually say.

Now I want to draw the Court's attention to Section 1.4. That section says that in order to approve coverage, UBH has to conclude that the member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors, also known as the "why now" factors.

This is really important. On its face this criterion says two key things. First, that the member has to have experienced

an acute change in her signs and symptoms and/or psychosocial and environmental factors. If there was no acute change, this criterion is not and cannot be satisfied.

1.4 says something else too. Assuming there is an acute change, 1.4 says that the acute change has to be severe or significant enough that because of that acute change, the member cannot be safely, efficiently, and effectively treated in any less intensive level of care. This centrality of acuity is evident throughout the common criteria.

Let's look for another example at Section 1.8. 1.8 says that in order for UBH to approve coverage, it has to have a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time.

What does that mean? Well, the guidelines tell us what it means on the next page. Section 1.8.1 says (reading):

> "Improvement of the member's condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in the level of care."

So, again, this means two things. There have to be acute signs and symptoms, and UBH has to believe that treatment will reduce or control them within a period of time.

How does UBH measure whether the acute signs and symptoms have been reduced or controlled? Well, that's in the next paragraph, 1.8.2. In this context, it measures the improvement

in the acute signs and symptoms by weighing the effectiveness of treatment against evidence that the signs and symptoms will deteriorate without the proposed treatment within the broader framework of the member's recovery, resiliency, and well-being.

This language is really interesting for another reason. Like so many other parts of the guidelines, UBH borrowed it from another source; and like it did with so many other sources, it used creative editing to fundamentally change the language's meaning to justify restricting coverage.

The reasonable expectation of improvement requirement comes from the CMS Medicare Benefits Policy Manual, but the CMS definition emphasizes that, particularly for patients with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration is an acceptable expectation of improvement.

UBH didn't just leave that out of its common criteria; it replaced it with the language in 1.8.1 rewriting the definition to make sure the focus was solely on reduction or control of the acute signs and symptoms.

UBH took a definition that it knew was generally accepted and narrowed it to suit its own purposes; and as the evidence will show, this is not an isolated incident but a pattern of cherry picking and manipulation of those sources on which UBH pretends to rely.

So those are some of the common admission criteria.

They're some of the hoops that the member has to jump through just to get coverage on day one, and we'll talk about more of them throughout the trial.

For now, let's look at the continued service criteria. These are the criteria that apply if the member is already admitted and UBH is deciding whether to continue providing coverage.

So continuing with Exhibit 5, let's focus on Section 2.1. This contains two vague requirements for continued coverage. First, that the admission criteria continue to be met. So all the stuff we just talked about still applies. There still has to be an acute crisis. UBH still has to find that you need the proposed level of care because of that acute crisis and that the services are expected to reduce or control the acute symptoms within a reasonable period of time.

Every one of those threshold requirements still has to be met, but now there's one more. You have to be receiving active treatment. The guidelines define "active treatment" as, among other things, services that are provided under a treatment plan that is, quote, "focused on addressing the 'why now' factors," close quote. It doesn't say "focused on addressing the member's underlying mental illness or substance use disorder." It doesn't say "focused on addressing the member's condition." It says "focused on addressing the 'why now' factors," which we know refers to the acute changes in signs and symptoms.

This means that once those acute changes in signs and symptoms are ameliorated, there can no longer be active treatment by definition; and if there is no active treatment, these guidelines say there is no coverage.

Now let's look at part three, the discharge criteria. This is how UBH decides when coverage should end. There's really just one criterion. If UBH finds that the continued stay criteria are no longer met, the guidelines say that the member should be discharged and UBH should deny coverage from that point forward.

And, of course, because the continued stay criteria required the admission criteria to be met, this means the moment one of those admission criteria ceases to apply, these guidelines say that the member is ready for discharge.

And lest there be any confusion about that point, the guidelines give examples of situations when the continued stay criteria are no longer met. The first one is that the "why now" factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care or no longer requires treatment -- or no longer requires care. Excuse me.

Remember the "why now" factors? Those are the acute changes. As soon as those improve enough that it would be safe to put the member in a lower level of care, never mind whether the treatment would be effective at that level or the most

effective at that level, these guidelines call for the denial of coverage.

All of these provisions interlock and they're mutually reinforcing. Among a number of other ways that they fall short of generally accepted standards, these criteria combine to preclude coverage in the absence of an acute crisis; and after a crisis has passed, they call for the denial of coverage even if the requested services are at the level of care that can most effectively treat the member's underlying illnesses and co-occurring conditions.

In short, it's no surprise that Jerry Niewenhous, the UBH employee who maintained the Level of Care Guidelines for more than 13 years, describes UBH's approach as, quote, "acute care utilization management," close quote.

Why does UBH have such fundamentally defective guidelines? The answer is going to be a pretty familiar one to the Court. It's to protect the company's bottom line. UBH's financial interests took precedence over what was clearly required by the plans it was administering fidelity to generally accepted standards of care.

There's no dispute that UBH has a structural conflict. With respect to its fully insured plans, UBH bears the risk for benefits paid, also known as the benefit expense, which of course means that more money paid for benefits equals less money in UBH's pocket.

But even with respect to its self-funded plans, it is in UBH's economic interest to minimize benefit expense because it is competing with others for the business of administering health insurance benefits.

And because both its fully insured and its self-funded plans condition coverage on services being consistent with generally accepted standards, UBH needed to develop a single set of clinical guidelines to make determinations under all plans.

The conflict in this case is no mere theoretical conflict. UBH's financial concerns were front and center for the people involved in writing and approving UBH's guidelines.

Throughout the class period, UBH's senior managers, who were regularly apprised of UBH's performance in relation to benefit expense and utilization forecasts and targets, participated in editing the guidelines and voted on whether to approve the guidelines.

The committee that approved the guidelines at UBH -- called the BPAC for some of the class period and the UNC at the end -- included members of UBH's Finance Department and its so-called Affordability Department, which is charged with developing initiatives to mitigate benefit expense.

And the individuals primarily responsible for maintaining UBH's guidelines were reminded time and time again of the centrality of UBH's financial concerns. And the Court will see

over and over again how concerns about not increasing benefit expense, or ben-ex, trumped considerations of what was supported by the evidence of generally accepted standards.

The evidence of UBH's conflict goes back to 2010 when UBH was faced with implementing the Mental Health Parity and Addiction Equity Act. That standard was a game changer. Among many other things, it outlawed insurance plan provisions that discriminated against those with mental illness by, for example, imposing day and visit limits on behavioral health treatment; for example, capping the number of days of residential or IOP treatment or the number of sessions of outpatient treatment covered under a plan.

The Parity Act prohibited that kind of plan-based quantitative limitation, so UBH decided on a mitigation strategy in UBH's words, using, quote, "concurrent review to ensure appropriate utilization," close quote. Rather than applying overt limits, UBH would keep a lid on utilization through its clinical review process by authorizing days and visits in bite-sized amounts, then conducting frequent concurrent reviews and issuing denials under its restrictive guidelines.

Post-parity UBH relied on its guidelines to drive denials, a fact the people who wrote and approved the guidelines knew very well.

UBH's concern for its own bottom line infected its

decision-making, including about its clinical guidelines throughout the class period. Like in so many cases, this motive evidence can best be seen through contemporaneous communications between individuals involved when they are facing a fork in the road.

The evidence will show that when faced with such decisions, this company consistently chose the path that would save it the most money even where this restricted coverage in violation of generally accepted standards of care.

Plaintiffs will present evidence of at least three examples of how UBH's focus on its financial interest impacted the guideline development process.

First is UBH's conduct when it figured out it had to cover Transcranial Magnetic Stimulation or TMS. TMS is a treatment that in 2008 the FDA found effective for treatment-resistant major depressive disorder. It's more expensive than some other forms of treatment, though. So UBH's first reaction was to just keep on considering TMS unproven for years after the FDA approval so that TMS treatment was administratively excluded under most plans as experimental.

Then UBH's denials started to get overturned on external appeal more and more often. So the company found it couldn't really continue calling TMS unproven. So in 2013, it finally recognized that TMS was effective and a generally accepted form of treatment in some circumstances.

But now UBH had a new problem. If TMS wasn't excluded, UBH was going to have to cover it because its plans covered generally accepted treatment. Even though this was just one treatment for one diagnosis, UBH was deeply concerned about the increase in benefit expense it was going to cause; a projected 4 to 9 cents in additional ben-ex per member per month amounting to a total of about 4.8 to 10.8 million per year.

UBH's first solution to this problem was that it would approve coverage for TMS under self-funded plans -- meaning someone other than UBH was paying -- but to continue automatically denying it if UBH was footing the bill.

It wasn't until legal came in and said, "Listen, you can't adopt different clinical policies for these plans just based on who is paying," so UBH went to its fallback position. It wouldn't automatically deny claims for TMS, but to make sure it didn't cost the company too much, it would, quote, "need to manage it very tightly," close quote. And that instruction was conveyed directly to the people drafting the guideline.

Another example of how UBH reacts at a fork in the road concerns Applied Behavioral Analysis or ABA, a treatment for autism spectrum disorder. UBH had Level of Care Guidelines and CDGs in place for ABA, which set a hard limit on the number of hours per week UBH would approve.

In 2016, the State of Indiana Department of Insurance instructed UBH to get rid of the hard limit. So UBH took a

look at its ABA guidelines and researched the criteria and figured out that aspects of UBH's guidelines were unsupported, meaning they fell short of generally accepted standards of care. So the guideline drafters proposed some revisions and the UMC approved them.

But this alarmed the Finance Department, which worried that removing the hard limit on ABA treatment in all states would lead to a significant increase in benefit expense for this widely used treatment, and so Finance escalated this issue all the way to the head of UBH, Martha Temple.

Ms. Temple's view was that even if UBH was required to comply with the Indiana mandate, for all other states UBH should not revise its guidelines for ABA even though the guideline drafters had concluded that the peer-reviewed evidence demanded it and even though the committee had already approved it.

Following Ms. Temple's instructions, UBH did not make the changes in its standard criteria. And Ms. Temple issued the following reminder to several members of the UMC (reading):

> "We need to be more mindful of the business implications of guideline change recommendations."

Nothing about medical necessity, nothing about whether this complied with generally accepted standards, nothing about whether this was consistent with the interests of plan beneficiaries. Just "be mindful of the business implications

of changes to the guidelines."

Third, the Court is going to hear quite a bit about UBH's decision on whether to adopt as its standard criteria for substance use disorders the ASAM criteria issued by the American Society for Addiction Medicine. As the Court will hear -- and this will not be seriously disputed -- the ASAM criteria are by far the most widely accepted reflection of the generally accepted standards for patient placement for substance use disorder treatment. It's the required criteria for substance abuse treatment under Medicaid in a majority of states, some states mandate it for commercial purposes as well, and even some insurers have adopted ASAM as their standard clinical criteria for substance use disorders.

Now, UBH has people on its staff that it considers subject matter experts with respect to substance use disorder treatment. They're called the SUDS team. Those clinicians recommended repeatedly throughout the class period that UBH adopt ASAM as its standard criteria; but UBH never did it, and the reason it didn't do it is that the Finance and Affordability Departments were unable to come up with a reliable estimate of the potential impact on benefit expense from making the switch.

Let's pause here for a moment. UBH is going to tell the Court throughout this trial that its criteria are fully consistent with ASAM. What UBH concluded internally, though,

was that it was impossible to model the benefit expense impact of adopting the ASAM criteria. UBH's criteria were so different from ASAM that UBH was unable to come up with a reliable prediction of what would happen to its bottom line if it made the switch.

And so because it couldn't get comfort about how much the change was going to cost UBH, the company repeatedly refused to adopt ASAM as its standard criteria, notwithstanding the recommendations of its own SUDS team.

Again, there were no substantive misgivings about ASAM, no argument that the ASAM criteria didn't reflect generally accepted standards. UBH's decision was driven solely by cold, calculated considerations of profit and loss.

This evidence and more will demonstrate to the Court that time and time again when UBH was faced with a choice between what was good for its own bottom line and what was good for plan benefit theories, it prioritized its own interests.

The *modus operandi* of this ERISA fiduciary, which is supposed to administer the plans solely in the interests of the beneficiaries, was to put its own interests first. Far from insulating the people charged with creating its clinical guidelines from financial considerations, UBH made sure those decision-makers were well aware of its own financial goals and the centrality of the clinical guidelines to the achievement of those goals.

In light of this deep and widespread conflict of interest, the pervasive guideline defects, and UBH's cherry picking from source material, the Court should evaluate UBH's decisions about the content of its guidelines and whether those guidelines accurately reflect generally accepted standards with a healthy dose of skepticism, to say the least.

The Court should also readily find that UBH breached its fiduciary duties of loyalty and care. And because UBH's guidelines so grossly departed from the standards required by the class members plans, UBH also violated ERISA when it used those plans to deny coverage to all the class members.

For that reason, when all the evidence has been offered, we'll ask the Court to find UBH liable on all counts and to move on to the remedy phase of the case.

Thank you for your time.

THE COURT: Thank you.

MS. ROMANO: Is it fine if I am at this lectern?

THE COURT: It's up to you.

MS. ROMANO: We just need to do one technical change.

OPENING STATEMENT

MS. ROMANO: Good morning, Your Honor. Jennifer Romano for defendant United Behavioral Health.

This case is about the work that UBH does to improve the health and well-being of millions of Americans across the country. Behavioral health presents serious challenges, both

on an individual basis, as well as on a public health basis.

Substance use and addiction, including an opioid crisis among our young adults, continues to plague our communities. Many people struggle with serious mental illnesses, sometimes lasting a lifetime. While many healthcare providers are committed to high-quality treatment for these conditions, the behavioral health field is faced with inconsistent practices, treatment methods that are not evidence based, waste, and sometimes fraud.

The core of UBH's business is to provide access to high-quality, effective, and efficient treatment and to control the cost of healthcare.

Many employers offer health insurance benefits to their employees, including benefits for behavioral health, and that includes mental health and substance use disorder treatment, and these employers select a company to administer those benefits for them. UBH is one such company.

UBH helps connect the member to quality healthcare providers to obtain treatment covered under the terms of the plan that is purchased by the employer.

In this trial, you will hear that over the class period thousands of employers turned to UBH to manage behavioral health benefits for their employees and their family members. UBH's job as the managed care company is to get these members access to the right care for their situation with the right

provider for the best outcomes.

UBH's employees will testify that they worked to make these members healthier by managing the benefits to cover medically necessary and effective treatment according to the terms of the plans purchased by their employers.

Now, what does UBH do for employers and members? You will hear testimony that UBH is a company focused solely on behavioral health. It employs over 1,000 licensed clinicians and more than 70 board-certified psychiatrists who combine their specialized expertise to address behavioral health challenges and advance quality care for individual members.

UBH's mission is evidence-based medicine. It helps its members access the most effective and appropriate care for their individual circumstances consistent with the coverage provided in their health benefit plans.

UBH maintains a nationwide network of behavioral health providers and assesses the quality of care received by its members by monitoring certain metrics, such as readmission rates, to identify gaps in care or ineffective treatment.

Medical necessity and evidence-based treatment are requirements for health benefit plans. You will hear that although the vast majority of services are authorized for coverage under the plans, the health benefit plans in this case do not cover all treatments a member might seek or receive. Instead, you will learn that one of UBH's responsibilities to

the employers that purchase the health benefit plans and to the members is to authorize benefits where services are medically necessary and where the plan provides coverage.

The many different health benefit plans that will be introduced into evidence will have at least one thing in common. They grant UBH the discretion to interpret the plans and manage the behavioral health benefits under those plans; and as the plans at issue provide, UBH creates clinical guidelines to help its reviewers administer the benefits and determine whether coverage is available.

You will hear that it is common for companies like UBH to develop their own guidelines. In fact, it is so common that there is a nationally accredited process for doing so and UBH has earned that accreditation.

In this class action case, plaintiffs challenge 222 of UBH's guidelines on their face claiming that each one is inconsistent with all of the plans UBH administers. The evidence will show that UBH's guidelines are consistent with the plans and are consistent with generally accepted standards of care.

There will be 129 different ERISA health benefit plans that will be introduced into evidence in this trial. These are the plans for the named plaintiffs and randomly selected plans that were selected for the class members and produced in discovery in this case.

You will hear testimony that these are the documents, the contracts, that set forth the scope of what healthcare services are covered and what healthcare services are not covered for each of the class members.

And you will hear evidence that these plans changed regularly, often annually, and their language varies depending on the employer.

Now, all of the health benefit plans at issue are managed care plans. You will learn that this means the health benefit plans cover some but not all healthcare services; and as the administrator, UBH works with the members and the providers to help members obtain quality and efficient healthcare services under those plans.

You will see that the health benefit plans provide that coverage is not always available when a member or his treating provider recommends it.

Barry Dehlin, UnitedHealthcare's product director, will explain the health benefit plans and what UBH is hired to do for the plans and the plan members, including the class members in this case. He will explain that UBH's job is to build a network to ensure that the network providers are of proper quality.

UBH's job is to coordinate the member's care among multiple providers. It's to determine whether treatment the member receives is covered by the member's health benefit plan.

And UBH's job is also to address fraud and quality of care issues. UBH is hired by employers to manage the plans efficiently, make sure necessary and effective care is covered, and that unnecessary and ineffective care is not.

The evidence will show that the health benefit plans give UBH the discretion to interpret the plans, administer the benefits, and decide if the treatment is medically necessary.

And you will see the various ways that the health benefit plans at issue in this case give UBH the discretion to determine the right level of care. For example, you will learn that the health benefit plan applicable to one of the plaintiffs, Gary Alexander, provided that UBH will determine the appropriate setting for the treatment.

You will see that other health benefit plans in evidence in this case gave discretion to UBH to select the location of service.

Mr. Dehlin will also explain how the health benefit plans vary in the scope and limitation of the covered benefits.

All of the 129 plans that will come into evidence will include a requirement that treatment be consistent with generally accepted standards of care or with professional standards, but you will see that the plans do not say that they cover all services that are consistent with generally accepted standards of care.

For example, the evidence will show that in the benefit

plan for one of the plaintiffs, Natasha Wit, in the definition of "covered health services," all of the following five criteria need to be met of which one is consistency with prevailing medical standards.

Similarly, in the same plan in the exclusions, the evidence will show that any of the following can be reasons for an exclusion, and inconsistency with generally accepted standards of cares is one of the five reasons listed.

Mr. Dehlin will also explain that the 129 health benefit plans vary in the requirements for coverage and in the exclusions and limitations that apply specifically to behavioral health services. For example, you will see that some of the plans in evidence exclude services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments, or crisis intervention to be effective.

Others provide that benefits are only available for services provided in the least costly treatment setting, which in the judgment of the plan and its authorizing agent -- that's UBH -- is medically necessary for the individual patient's condition.

Some do not cover residential treatment at all and others limit coverage for residential treatment to short-term intervention to stabilize the presenting problem within a reasonable period of time.

It will be Mr. Dehlin who explains this variation in the plan language. Plaintiffs' experts will offer no opinion on the plans or what they mean. And these differences in the plans, they do matter because if the guidelines are consistent with the plans, there is no violation of ERISA.

In addition to making coverage decisions, you will hear testimony from UBH employee Nisha Patterson who will testify about how UBH uses some of the data that's been referred to, including data about benefit expenses, to address quality of healthcare services and keep healthcare affordable.

Ms. Patterson is the head of the Affordability Department, that's been mentioned this morning as well, and this department is focused on quality and affordability initiatives throughout the company.

She will explain how UBH uses data about admissions and services to come up with initiatives aimed at improving care and quality and outcomes for members. For example, Ms. Patterson will explain the Affordability Department's efforts to tackle the challenges members face when seeking treatment from some providers outside of UBH's network.

You will hear testimony that members suffering from substance use sometimes end up in high-cost destination treatment centers outside of their communities and away from their support networks. These facilities often are not part of UBH's network of credentialed providers, and Ms. Patterson will

explain this means UBH has not vetted them for quality and effective treatment.

Ms. Patterson will testify that by analyzing utilization and claims data, UBH is able to identify the providers that have higher readmission and relapse rates than would be expected. The Affordability Department addresses these situations with projects that promote in-network providers who have been vetted for quality care through the credentialing process and with projects that support post-discharge care for members when they return home.

Now, as we heard this morning, plaintiffs point to the role of the Affordability Department and UBH's role as a payer of benefits to assert that UBH's guidelines at issue in this case are influenced by a conflict of interest.

And we heard a little bit about the difference between self-funded and fully funded plans as well.

Now, we will hear numerous witnesses testify about the creation and approval of the UBH guidelines, and none will testify that the Affordability Department or any financial metrics influenced the language of the UBH guidelines at issue in this case.

In addition, 62 percent of the class members were covered by self-insured ERISA plans, and you will learn that these health benefit plans are created by larger employers that decide to underwrite their own health plan for their employees.

THE COURT: Why does that matter?

MS. ROMANO: Why does it matter? It matters --

THE COURT: Yeah. Why does it matter?

Let me tell you the import of my question. The guidelines apply across plans; right? They're not limited to fully insured plans or employer self-insured plans; right?

MS. ROMANO: That is correct.

THE COURT: So any given guideline that is under challenge here is applicable to a fully insured plan; right?

MS. ROMANO: That is correct.

THE COURT: Okay. So why isn't there a structural conflict for that reason?

MS. ROMANO: Your Honor, there is a potential structural conflict for 38 percent of the class members.

THE COURT: No, no, not 38 percent of the class members. All of the guidelines are written without regard to which of the plans. So they are written, among other things, for fully insured plans. Therefore, when deciding whether or not the guidelines are consistent with generally accepted medical criteria, why doesn't UBH operate under a structural conflict? Because some, those guidelines are applicable and they know they're applicable to fully insured plans. Isn't that the definition of a structural conflict?

MS. ROMANO: There would be a structural conflict in creating the guidelines, but why does it matter that 62 percent

are self-insured class members?

THE COURT: Right.

MS. ROMANO: It's because when evaluating the skepticism to be used with respect to a structural conflict, if that is applied, the fact that a majority of the membership is -- there is no structural conflict should be considered as part of that evaluation.

THE COURT: Got it.

MS. ROMANO: And with respect to the 38 percent, Your Honor, you will learn that UBH provides administrative services for these folks, as well as having the risk for the benefits; but there will be testimony from Mr. Dehlin that UBH builds the cost of providing the benefits into the monthly premiums it charges for providing insurance and it adjusts those premiums on an annual basis to address changes in the cost of benefits, which the case law has addressed and considered when evaluating the structural conflict as well.

Now, plaintiffs challenge 222 UBH guidelines that were used to determine coverage during the class period. Let's talk a little bit about what those guidelines are.

Eight of the 222 are the Level of Care Guidelines, and only three levels of care within those guidelines are at issue in this case, and Ms. Reynolds went over them. It's residential, intensive outpatient, and outpatient.

Now, there is a separate guideline for ABA and there is a

separate guideline for TMS, and those were two specific issues that were discussed quite a bit this morning already; but it's very important to understand that those guidelines, the TMS and ABA, they're not challenged in this case and they were not used for any of the class members.

These Level of Care Guidelines are updated annually from 2011 to 2017 and they did change in language. Ms. Reynolds talked about the 2015 guidelines and walked through them very carefully, but it's important that they changed.

And specifically the "why now" language that we heard quite a bit about today and its tie to acute conditions and circumstances, it was not in the guidelines in 2011 or 2012 or 2017. And the words "why now" were in the guidelines in 2013 but with no connection to the acute changes that we heard about this morning.

And all of the Level of Care Guidelines explicitly provide that they are to be used flexibly and are intended to augment but not replace sound clinical judgment. That's in the language of the guidelines.

And you'll see that the Level of Care Guidelines give the medical directors -- and that includes every one of the doctors with authority to authorize or deny coverage -- they were given the discretion to make exceptions to the guidelines. You will see that many of the 129 health benefit plans in evidence also provide for those exceptions.

Now, these Level of Care Guidelines were used for the coverage decisions for approximately half of the class members.

The other guidelines that are challenged in this case are coverage determination guidelines, and we didn't hear about those too much in the opening. There are 215 coverage determination guidelines that are challenged in this case. These guidelines are different because they are specific to a particular diagnosis.

So, for example, there are some specific to obsessive/compulsive disorder, some to major depressive disorder, and a host of different conditions. These guidelines were also updated annually and changed from year to year for the different diagnoses.

With one exception, the coverage determination guidelines that are challenged in this case are challenged only to the extent they incorporate the Level of Care Guidelines, but the evidence will show that not all of the 215 coverage determination guidelines that are challenged incorporate the Level of Care Guidelines. For example, while some of the challenged coverage determination guidelines include the full language of the Level of Care Guidelines, some include just portions of the Level of Care Guidelines, others just reference them or cite to them, and others don't incorporate or refer to them at all.

Now, there will be a lot of evidence, and it will likely

be more in UBH's case, about the process for creating these guidelines, and the primary witness talking about that will be Jerry Niewenhous. He's a master's level social worker and one of the people who oversaw the updating of the guidelines from 2003 to 2016. He's going to explain the formal process that was used to update them and it happened every year.

THE COURT: He's going to be here in person?

MS. ROMANO: He will be here in person, both in plaintiffs' case, as well as defendant's case.

Mr. Niewenhous will explain that throughout the year, he and his colleague, Loretta Urban, who will not be here -- she's a video -- reviewed other clinical guidelines. They reviewed evidence reviews and consensus statements created by the government and professional associations to identify new evidence or information to enhance the guidelines.

Then, typically toward the end of the year, they would create a work plan for the formal annual review of the Level of Care Guidelines. Mr. Niewenhous will explain that he would include in the work plan a review of all of the references that were in the then current year's guidelines, including the ASAM criteria which we've heard about today, including the CMS guidelines, which we heard about today, and materials from a variety of other professional associations, and they were looking to see if those materials had been updated or changed. You will see that these are some of the same sources that

plaintiffs' experts will rely on as well.

Mr. Niewenhous will explain that at the same time that he and Ms. Urban were reviewing these materials, they would send a copy of the then current Level of Care Guidelines to a long list of clinicians for comment. It included at least 20 internal UBH doctors. That list included 20 to 30 network doctors and facilities across the country. These are not UBH doctors. These are external facilities and providers.

And beginning in 2012, the list of recipients also received several provider specialty associations. They asked for comments about the guidelines to the Center for Clinical Social Work, to ASAM, to the American Psychiatric Association, and these providers were asked specifically to comment on whether the guidelines should be changed and, if so, why and how.

The template letter seeking this input will be introduced into evidence, as well as the list of providers who were sent them.

Now, Mr. Niewenhous will testify that after the comments were gathered, he would compile the comments into a spreadsheet, which included the detailed comment, the person who provided it, and the organization. And he would then present it to a committee called the Level of Care Work Group. This work group included Chief Medical Officers Dr. Bill Bonfield and Dr. Rhonda Robinson-Beale, both who we will be

seeing by video because they're no longer employees of UBH; and the Level of Care Work Group included the chair of the Behavioral Policy and Analytics Committee, Dr. Lorenzo Triana. Dr. Triana will be here both in plaintiffs' case, as well as defendant's.

And each year this Level of Care Work Group would meet by phone and they would review the feedback that came in from all of the different folks who were asked to comment.

You will see that UBH received a variety of comments over the years -- the actual spreadsheets of the comments will be introduced into evidence -- and those comments ranged from fully supportive of the guidelines to comments on different issues from the ones that the plaintiffs now raise to some comments that are similar to the issues raised by plaintiffs.

Mr. Niewenhous will testify that the Level of Care Work Group reviewed the comments on the spreadsheets, they discussed whether any changes should be made, and sometimes they performed follow-up research in response. The evidence will also show that UBH made changes to the guidelines in response to many of the comments.

But this wasn't the end of the process. After this work group reviewed the comments and formed their recommendations for changes to the Level of Care Guidelines on an annual basis, they presented them to a separate formal committee, the Behavioral Policy and Analytics Committee, for approval. This

committee was led by Dr. Triana and it included several doctors and clinicians, as well as some of the representatives that Ms. Reynolds spoke about.

This committee is called the BPAC Committee. It met twice a month, and you will see the meeting minutes showing that each year they reviewed the recommended changes to the Level of Care Guidelines that were presented to them, they discussed the recommendations, sometimes they made revisions to the recommendations, and they approved the new Level of Care Guidelines.

These meeting minutes do not reflect any conversations about profits or benefit expenses in connection with approving the Level of Care Guidelines at issue in this case, and the testimony of Mr. Niewenhous and Dr. Triana will confirm these topics were not discussed.

And there will be evidence this process described by Mr. Niewenhous and Dr. Triana satisfies the requirements prescribed by the accrediting bodies. There were two accrediting associations, the Utilization Review Accreditation Committee called URAC, and the National Committee for Quality Insurance, sometimes called NCQA.

An expert in managed care accreditation and compliance, Thomas Goddard, will testify that URAC and NCQA have developed widely accepted accreditation criteria for the development of clinical guidelines by managed care organizations like UBH. He

will explain that these accreditation requirements were developed to establish a national standard for creating guidelines, and he will testify that UBH's process for creating the guidelines satisfied the national accreditation criteria and that its process of seeking input from all of those outside providers exceeded this national standard.

And UBH's efforts to seek outside input were not limited to the annual review process. For example, you will hear evidence that it separately sought input on its guidelines when it learned of new resources, like the Parity Implementation Coalition, and the Association for Ambulatory Behavioral Healthcare.

And in 2013 when a new version of the ASAM criteria was announced, UBH hired as consultant one of its co-authors, Gerald Shulman, to provide his thoughts on how the UBH guidelines compared to the new ASAM version and to offer his recommendations to the UBH guidelines. UBH considered the comments from each of these resources and made changes to the guidelines in response.

Now, there will be many doctors, psychiatrists, who will testify in this trial about the content of the guidelines and what they mean. This will be the evidence of what they mean. It will not be argument of counsel.

Now, some of those doctors who will testify -- and all three of those will be here in person, Your Honor; one of them

is already in the room -- they will be UBH doctors, and they will testify about what the words in the guidelines mean in isolation and what they mean when they are doing their jobs.

Dr. Allchin is a board-certified child and adolescent psychiatrist. He will testify about what the guidelines mean for him at UBH and what they mean for the numerous other child and adolescent psychiatrists who are called upon to use them for other members. Dr. Danesh Alam is a board-certified psychiatrist with a specialty in addiction medicine. He also continues to practice psychiatry, and he will testify about what the words mean for him and the doctors using them for substance use decisions. Dr. Martorana, who supervises numerous other doctors at UBH and makes coverage decisions, will testify about them as well. These doctors will explain that most care is authorized.

And the first step in determining whether treatment is medically necessary is for the provider to speak with a master's level clinician at UBH. This master's level clinician is called a care advocate. When the care advocate speaks with the provider, they discuss the information set forth in the best practices section of the guidelines, and this is the long list of items that are in the guidelines and set forth the criteria and facts that are to be collected and considered by the care advocate. They include numerous different issues, one of them is specifically co-occurring behavioral health and

physical conditions that the member may be experiencing, and another one is developmental age and history.

The care advocate and the provider also talk about the treatment plan that the provider has created for the member to make sure that evidence-based medicine is being practiced, and the care advocate takes this information down and it's maintained in UBH's electronic system.

The care advocate considers this information and UBH's guidelines for coverage, the specific guideline that applies to the specific plan and diagnosis, and in most circumstances the coverage is authorized by the care advocate during that conversation.

Now, as set forth in UBH's utilization management program description, which will be introduced into evidence, if it does not appear to the care advocate that the services are covered, he can discuss the case with a UBH doctor in scheduled rounds that are held throughout the week; and if he still has concerns, the next step is to send the case for a consultation for the doctors to simply talk or to a peer review. A care advocate cannot deny coverage on his own.

You will learn that a peer review is required for any denial of authorization.

And a peer review, we will learn, is a doctor-to-doctor discussion about the member's care so that a UBH doctor can learn more about the case and determine whether the requested

services are covered under the plan.

The UBH doctors who will testify in this trial will explain that when they are assigned to a case for a peer review the doctor reviews the information that was collected by the care advocate as well as other available information about the member, like their treatment history and diagnoses.

And then the doctor gets on the phone with the provider and has a doctor-to-doctor conversation about the member and the proposed treatment.

There is no script for this conversation. It is a case-specific conversation between doctors about the member, their condition, the treatment plan, and all of the facts that support the decision about the right level of care to safely, effectively, and efficiently treat the member, just as it's set forth in the guidelines.

There is no single-minded approach in this conversation to focus on acute symptoms. They are talking about all of the information that has been collected in the process. And the UBH doctor considers this information and the guidelines and makes a decision about whether the requested treatment is covered.

And you will hear that if the UBH doctor decides the treatment is not covered, he often offers a different level of care for the member. The provider and member are then informed of their right to appeal if the authorization is not given, and

sometimes there's a right to a second appeal as well.

Now, Dr. Allchin, Dr. Alam, and Dr. Martorana will explain why the guidelines used for these decisions are consistent with generally accepted standards of care and are designed to provide necessary, high-quality treatment to UBH's members.

In addition, an external expert, Dr. Thomas Simpatico, will testify in UBH's case about his review and opinion of the guidelines.

Dr. Simpatico is a board-certified psychiatrist. He has 30 years of experience treating patients. He's a professor of psychiatry at the University of Vermont Medical School, former medical director. And he was the chief medical officer at the Vermont Medicaid Authority.

Dr. Simpatico has never worked for a managed care company. He has never worked for an insurance company. And he will share his opinion that the guidelines from 2011 to 2017 are consistent with generally accepted standards of care.

Now, there will be many witnesses, doctors who will testify about what are the generally accepted standards of care.

The UBH doctors and Dr. Simpatico and plaintiffs' experts are going to point to several outside sources to describe what are the generally accepted standards of care in treating patients. These doctors will explain, and even the plans at issue in this case recognize, there is not one static or single

source for standards of care. Instead, there are many sources.

And while all the external guidelines and guidance are not the same, Dr. Simpatico will opine that they do encompass some core principles.

He will explain that a fundamental principle for health treatment is that the behavioral health treatment is that the patient should be treated in the least restrictive level of care that is safe and effective.

If they can be safely and effectively treated in outpatient treatments, it is not medically necessary to admit them into a residential treatment center.

He will further explain that effective care should limit interference with an individual's life experiences, with their family and community, and minimize dependence on the treatment setting to prevent atrophy during treatment.

And he will testify that this is essential for generally accepted standards of care if the treatment can be provided in a less restrictive level of care, safely and effectively.

And, in addition to this critical principle, Dr. Simpatico will also testify that treatment should be medically necessary; that generally accepted standards of care require that a treatment be individualized with a unique treatment plan for the patient based on their unique conditions; that the treatment plan should have the goal of improving the member's behavioral health; and that treatment methods should be

evidence based.

And while the UBH guidelines evolved over the years, they differed in numerous ways from 2011 to 2017. Dr. Simpatico will testify that all of these core principles are in UBH's guidelines, and UBH's guidelines are consistent with generally accepted standards of care.

Dr. Simpatico will also opine that there is no overemphasis in the guidelines on the factors that led to the patient seeking care, sometimes call the "why now factors." And he will testify that there is no overemphasis on the presenting symptoms in the guidelines or on trying to assure that the member will improve.

Dr. Simpatico will explain that these considerations are essential for sound clinical practice, and they're appropriately set forth in the UBH guidelines.

Now, you will also hear testimony that the key principles of the external guidelines plaintiffs rely on are also reflected in the UBH guidelines.

You will hear evidence about the ASAM criteria. We've heard about it today already. And Dr. Fishman, who I believe is testifying today, will testify about ASAM criteria.

Well, in addition, in UBH's case Dr. Danesh Alam will talk about the ASAM criteria. In addition to serving as the medical director for UBH and practicing psychiatry in a residential setting, Dr. Alam also recently served as the president of the

Illinois chapter of ASAM. He will explain the six dimensions of ASAM. And he will explain that, yes, UBH's guidelines are consistent with ASAM's six dimensions.

You will also hear testimony about the LOCUS and CA-LOCUS tools from some of plaintiffs' other experts. Dr. Simpatico will address the LOCUS and CA-LOCUS criteria.

Dr. Simpatico is a member of the American Association of Community Psychiatrists. That's the organization that created the LOCUS tool. He will explain that the six dimensions of both LOCUS and CA-LOCUS are consistent with UBH's guidelines, and he will also offer his opinion that the LOCUS guidelines are difficult to use and poorly designed to make decisions.

Now, when this trial is over, the Court will be tasked with deciding whether plaintiffs have satisfied their burden of proof on all of their elements under ERISA on a class-wide basis. And there are at least five issues that were addressed by the Court on which plaintiffs will not satisfy their burden of proof.

First, was UBH acting as a fiduciary when it promulgated the 222 guidelines at issue?

The plan documents will show that the guidelines are not part of UBH's fiduciary obligations because they are incorporated into the plans.

Second, were the guidelines binding or could the reviewer allow treatment that was inconsistent with the guidelines?

The evidence will show that the guidelines are just that. They are guidelines. They are not an algorithm and they are not a script. UBH's doctors will testify that they are drafted to permit broad clinical judgment, and they explicitly permit the doctors who applied them to approve treatment even if it was inconsistent with the guidelines.

Third, are the guidelines at issue inconsistent with the plans? This question requires consideration of 129 plans and 222 guidelines, which will all be in evidence in this trial. The evidence will not show that each of the plans deviated from each of the guidelines for each of the years.

Fourth, did the guidelines contain restrictions that would not allow coverage for treatment within the generally accepted standards of care?

The testimony of UBH's doctors, who helped create the guidelines and who interpret the guidelines, will be that the guidelines provide for coverage consistent with generally accepted standards. This testimony will be confirmed by Dr. Simpatico, who will explain the clinical basis for the guidelines and their alignment with accepted standards.

And, fifth, did UBH abuse its discretion in creating the guidelines?

There will be no evidence that the guidelines challenged in this case were influenced by a profit motive. What the evidence will show is that UBH performed its fiduciary

obligations with diligence, with due care, and in good faith, and the guidelines are a reasonable interpretation of the plan terms.

Thank you very much, Your Honor.

THE COURT: Thank you.

Okay. Call the first witness.

MR. GOELMAN: Your Honor, before we call Dr. Fishman, I want to note for the record, I didn't want to interrupt Ms. Romano's opening, but I assume our objection to Mr. Shulman's report was preserved. That was the subject of one of our motions in limine.

THE COURT: I don't know. I did whatever I did in the motions in limine. What did I do?

MR. GOELMAN: We objected as undisclosed expert opinion and hearsay. And the Court denied our motion in limine.

THE COURT: Well, that usually preserves whatever arguments made in the motion in limine.

MR. GOELMAN: Thank you, Your Honor.

THE COURT: Okay.

MS. REYNOLDS: Your Honor, at this time, the parties have agreed that we would like to move the Guidelines into evidence. All of the witnesses will be referring to them.

The parties have stipulated as to authenticity and admissibility. And, as a matter of convenience, it makes sense

that they come into evidence now.

And so the plaintiffs, therefore, move Exhibits 1 through 224 into evidence. And the defendant joins us in that motion.

MS. ROSS: No objection.

THE COURT: Okay. 1 through 224 are admitted.

MS. REYNOLDS: One other matter.

As the Court notes, the parties entered into a stipulation concerning certain information in the guidelines, which we filed with the Court on June 9th. And we also attached it to the pretrial order.

The stipulation needs to be part of the trial record. And I think the most efficient way to do so will be to mark it as a trial exhibit, but I wanted to make sure that, first, was acceptable to the Court.

THE COURT: Sure.

MS. REYNOLDS: We'll prepare that and admit it.

THE COURT: What's --

MS. ROSS: No objection.

MS. REYNOLDS: Thank you, Your Honor.

THE COURT: Do you know what the next exhibit in order is?

THE CLERK: If it's the plaintiffs' exhibits, my guess is 880. Is that the next number in line for you guys?

MR. ABELSON: That's right.

THE COURT: All right. What's the docket number?

MS. REYNOLDS: The docket number is 257.

THE CLERK: 257 in the Wit one. So that's our new Exhibit 880.

(Trial Exhibit 880 marked for identification.)

MS. REYNOLDS: Yes. And we'll prepare a stamped version.

THE COURT: So 880, did you say, Karen?

THE CLERK: 880, yes.

MR. GOELMAN: I call Dr. Marc Fisherman.

THE CLERK: Dr. Fishman, please raise your right hand.

FISHMAN, PLAINTIFFS' WITNESS, SWORN

THE CLERK: Thank you. Have a seat. Make sure you speak clearly into the microphone for our court reporter here. There's, of course, water if you need it.

Could you please state your full name for the record and spell your last name.

THE WITNESS: Yes. Marc Fishman, F-i-s-h-m-a-n.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MR. GOELMAN

Q. Good morning, Dr. Fishman.

A. Good morning.

Q. Are you here to offer the court your opinions related to UBH's substance abuse guidelines?

A. I am.

Q. Can you briefly describe your educational and professional background.

A. Sure. I'm a psychiatrist by training and specialize in addiction psychiatry and addiction medicine.

I went to medical school at Columbia University. I did a residency in general psychiatry at University of Johns Hopkins hospital. I did a fellowship in motivational -- motivated behaviors and addiction there.

Q. What did you do after that?

A. After that, I was on full-time faculty of psychiatry for a time. Now, I'm a part-time faculty there and am the medical director of a community treatment provider for addictions and co-occurring disorders called Maryland Treatment Center.

I do research in addiction. I do treatment in addiction. And I do administration in addiction programming, trying to develop additional program with both adolescents, young adults, and adults to deliver care for addiction treatment.

Q. Do you have any subspecialties within addiction medicine, Dr. Fishman?

A. Within addiction medicine, I've concentrated on the treatment of young people, to some extent. That's adolescents and young adults. Have specialized in the treatment of opioid use disorders and the use of medications.

I have focused on thinking about systems of care, treatment programming development, levels of care and levels of

care guidelines, treatment matching strategies, which patients go where.

Q. Do you still treat patients as well, Doctor?

A. That's right. One of the central things I do currently in my career is maintain a direct clinical experience, maintaining a caseload of patients, both with an outpatient clinic within the Maryland Treatment Center's community treatment program that I spoke about, also supervising physicians and programs throughout, sometimes covering for them, treating patients at all levels of care, from inpatient to residential to intensive outpatient, to outpatient.

Q. Dr. Fishman, can you look at your screen and see if Trial Exhibit 670, for identification, is there.

A. Yeah.

Q. Is that your CV and a list of publications?

A. It is.

Q. And does that provide a more detailed description of your professional background and research?

A. Yes, it does.

MR. GOELMAN: Plaintiffs' offer 670, Your Honor.

MR. RUTHERFORD: Objection, Your Honor.

THE COURT: Sustained.

MR. GOELMAN: Your Honor, there was no objection listed when we provided our disclosure of exhibits.

MR. RUTHERFORD: We objected to this on hearsay

grounds.

THE COURT: So, people, we're going to have to get this straight. There will be no objecting at the trial for something that is not objected to before.

Also, why do you care? Why do you care?

MR. RUTHERFORD: I'll submit.

THE COURT: No, no, no. Why don't you waive your objection. Why do you care? This is a bench trial. I'm not a jury.

MR. RUTHERFORD: Your Honor --

THE COURT: I'm probably not even going to go look at it again. But if I do, who cares? He went to John Hopkins.

MR. RUTHERFORD: That's fine, Your Honor.

THE COURT: Great. It's admitted.

(Trial Exhibit 670 received in evidence.)

THE COURT: Let's concentrate, folks. This isn't a jury trial. And there's a temptation, when it's not a jury trial, to think that just because it's a judge there's no cost for objecting. There's a cost for objecting. I'll think you're unreasonable.

So let's focus only on objecting to those exhibits that really matter in your case. Okay.

MR. RUTHERFORD: Yes, Your Honor.

THE COURT: Thank you.

\\\

BY MR. GOELMAN:

Q. Dr. Fishman, can you describe what ASAM is.

A. Sure. ASAM stands for the American Society of Addiction Medicine. It's a professional society that pools people who specialize in the treatment of addictive disorders, substance use disorders, physicians particularly, although nonphysicians are now included.

And there are some 3- or 4,000 members, and it is the premiere professional organization that represents addiction medicine, addiction medicine practitioners. It advocates for patients. It works on policy matters. It works on treatment matters. It publishes the ASAM criteria, which we'll be talking about in some detail.

But in broadbrush strokes, it is the professional society that represents addiction medicine for the United States.

Q. And is one of the functions of ASAM to establish the state-of-the-art consensus for how to treat persons with substance use disorder?

A. Yeah. It spent considerable effort developing a variety of guidelines about different aspects of treatment for patients with substance abuse disorder, that's correct.

Q. You mentioned the ASAM criteria. Could you tell the Court what they are?

A. Sure. ASAM criteria is a document that has now been around for two or three decades; in its evolution, now in a

third edition published in 2013. Before that, a second edition revised, published in 2001.

And this is a document that does a number of things. It establishes an assessment protocol or a system of teaching practitioners how to take patients as they present for care for substance use disorders and do a full multidimensional, multicomponent holistic assessment -- we can talk more about how that's done -- according to six particular assessment dimensions.

It also articulates the treatment levels of care. That is where treatment gets done for patients at different kinds of programs called levels of care.

And, then, most importantly, it -- and this is the kind of meat and potatoes of the document -- it contains treatment-matching strategies, particular guidelines and decision rules for how to take assessment material, translating that into the needs of patients, what are the particular kinds of treatment they will need, and matching those treatment needs to the levels of care of where they should receive that kind of treatment. So criteria for placing patients in treatment levels of care.

Q. Before we get into the substance of the ASAM dimensions and levels of care, could you describe whether you had any involvement in the development of the ASAM criteria?

A. I did.

Q. And, if so, what?

A. I was recruited by the chief editor, Dr. David Mee-Lee, in the late '90s to join the steering committee as a coauthor or a deputy editor for the second edition revised, which was published in 2001.

I've continued in that capacity since then, was involved in the group as a deputy editor for the third edition, and remain on the steering committee of the guidelines through ASAM and with other broader stakeholders of the ASAM criteria.

Q. Did you author any section of the ASAM criteria yourself?

A. I was a co-editor for the entirety, so contributed to most of the material. That would include reviewing drafts and participating with stakeholders, participating in field reviews, giving input to the drafting of material.

In particular, I was the chair of the subsection for treatment criteria for youth, for adolescents. So I headed that workgroup.

Q. Dr. Fishman, please describe the process by which the ASAM criteria are developed and edited and finalized.

A. Well, the ASAM criteria inherited and modified an existing body of work that already was articulating standards -- generally accepted standards of care. Documents like the Cleveland Criteria. And others had input.

But at the time of its coalescence into Patient Placement Criteria, editions 1 and 2, those became modified. They

evolved as standards evolved. And the -- as I became involved, for PPC-2R, the second edition revised, that process included gathering stakeholders, getting input from a broad variety of consensus-developing practitioners, payors, policymakers, researchers, trying to bring that material together, drafting a variety of materials, reviewing that back and forth with drafts over hundreds or thousands of hours of meetings and conference calls. Then, for each edition, putting that out to field review to an even broader group of stakeholders to get feedback about did it meet certain criteria for acceptability, for validity.

In addition, there's a large body of research that empirically validates the ASAM criteria. If you would like me to talk more about that, I can.

Q. Let's defer that.

I just want to show you what's been marked for identification Trial Exhibit 642 and then 662, and see if you will identify these exhibits as the two most recent editions of the ASAM criteria.

Yeah. This is the cover of the PPC-2R, or the second edition, revised in 2002.

Q. Okay. And that came out in 2001?

A. Yes.

Q. And what is the current iteration of the ASAM criteria?

A. The current edition is the third edition. The name has

changed slightly. It's now shortened to the ASAM Criteria; whereas, it has previously been called the ASAM Patient Placement Criteria.

Q. And is that Trial Exhibit 662?

A. And this is the cover of that volume, yes.

Q. So these are the two volumes that were in place between the years 2011 and 2017?

A. That is correct.

MR. GOELMAN: We offer Trial Exhibit 642 and 662, Your Honor.

MR. RUTHERFORD: No objection.

THE COURT: Those are admitted.

(Trial Exhibits 642 and 662 received in evidence.)

BY MR. GOELMAN:

Q. Dr. Fishman, can you describe, please, how the ASAM criteria are regarded in the field?

A. Yeah. The ASAM criteria are really quite broadly considered to be an expression or a reflection or an articulation of the generally accepted standards of care for how to do a comprehensive multidimensional assessment of patient severity, translate that into patient treatment needs, and, most importantly, how to do patient treatment matching to level of care through the decision rules that are the ASAM criteria.

And it is really, as far as I know, the primary and most

widely regarded such iteration. That is, it's broadly accepted, obviously, by ASAM but also by almost all experts in the field that I've encountered. It's referred to in most places as a, really, primary articulation of what the generally accepted standard of care in that realm ought to be.

Q. What about how ASAM is regarded by any government entities, state or federal. Do you have an idea?

A. Oh, sure. When the government has talked about patient placement matching strategies, generally ASAM is given as a prime example of where state of the art work has been and what the articulation of the generally accepted standard of care has been.

An example is that the federal agency SAMHSA, Substance Abuse Mental Health Services Administration, which has a subagency called CSAT, Center for Substance Abuse Treatment, it's the federal agency that articulates standards for treatment of substance abuse. It administers the block grant which funds most state level substance abuse treatment. It, for example, publishes a variety of guidelines and teaching materials.

One of the series of its teaching guidelines is called the treatment improvement protocols, or the TIPS. And one of those was particularly on this issue of level of care, placement matching, and treatment-matching strategies. And in that, ASAM was highlighted as a prime example of a placement-matching tool

that reflects the standard of care.

Q. What about insurance companies, are you aware of any insurance companies that use ASAM to determine matching placements in substance abuse disorder?

A. I don't know comprehensively, but I know that Aetna has adopted it. I know that Beacon, formerly Value Options, has adopted it, yes.

Q. Dr. Fishman, you testified about five minutes ago that ASAM is an iteration of the generally accepted standards of care.

Do you mean to suggest that ASAM criteria are the only iteration of the generally accepted standard of care for treating substance use disorders?

A. No. First of all, the ASAM criteria are not as broad as to attempt or to be ambitious enough to describe all of the aspects of the treatment of the substance use disorders.

But in the sub realm of treatment matching and placement decision criteria, it's not the only possible articulation. It has a particular method. It has a particular enumeration of the levels of care or assessment dimensions.

But they could be done in a different way that would be just as valid. It's not that it's the only articulation or reflects the only standard of care. But I think it does it in a very good way, in the most comprehensive way, that I have seen to date. And I think it's generally regarded as such.

If the material that is, you know, there articulated were expressed in a different way, in a different numbering, with a different set of jargon, that would be okay. But I think it would be fair to say that core principles that are contained in the ASAM criteria would have to be articulated for any other version of it to meet generally accepted standards of care.

If you didn't have those core things, it wouldn't meet the generally accepted standards of care, even if it was articulated in a different way.

Q. Dr. Fishman, you testified that ASAM is the most widely accepted and used of the iterations of generally accepted standards of care that you're aware of. In your opinion, is there a close second?

A. Not that I know of. There are a lot of examples in the way that many states implement, mandate, recommend, insist upon the use of the ASAM criteria.

For example, some states just generally mandate that all placement matching within the state needs to be done. Some may limit it to mandate for the public sector. Some may mandate it for state-funded programs.

Some may bake it into the very definitions in regulation for what constitutes a particular level of care using the ASAM descriptions and the enumeration in the ASAM levels.

Some may bake it into the requirements for substance use disorder treatment professional licensure and certification of

therapist or substance abuse counselor. It may be required.

It may be required in some states as a condition of meeting certification for a program, that a program must adhere to the ASAM criteria.

So there's a variety of different ways. But a lot of different places that I've encountered have really endorsed it as a standard.

Q. Dr. Fishman, earlier you were about to talk about empirical studies that you were aware of testing the efficacy of the ASAM criteria. I stopped you then, but could you just very briefly describe anything you're aware of?

A. Sure. And cut me off if I go, because I can go on.

But the idea is that, not only does it reflect a consensus of experts that's been refined by testing in field review with a broad, broad array of stakeholders, it's also been scientifically tested.

And, really, all the work that I know about that has explored, in a research sense, this tricky question of SUD placement treatment matching has been based on the ASAM criteria. It's really the foundation for the entire scientific field of SUD treatment matching.

So a core group of researchers have done a lot of work on this over a couple of decades, much of this funded by NIDA; that is, the National Institute of Drug Abuse, but also from other sources.

Dr. David Gastfriend has been a leader in this field at the time that he was at Harvard. But other people -- Jim McKay, Steve Magura from New York -- other people have contributed. And so there's a bunch of different interesting empirical findings.

First, that the ASAM criteria has been validated as a tool to provide accurate assessment of patients that is stable over time; that the six assessment dimensions and the factors included in the ASAM aggregation of treatment needs are stable over time and can be compared to other instruments used in substance use research of known psychometrics of known validity, like the addiction severity index and others such in the way that you compare and you see that it's valid.

There have also been, more importantly, good studies of looking at outcomes from using the treatment matching decision rules in the ASAM criteria.

So, first, by looking retrospectively, if we matched, did patients have better outcomes than if we didn't match. If patients ended up at a level of care that was recommended by the ASAM criteria, was that better for them than if they didn't, better for them in terms of dates of substance use, in terms of relapse, in terms of downstream hospitalization, in terms of functional outcomes and the like.

And then there are a couple of studies, as well, that also use an even further level of evidence than we use in medical

science, which is the prospective randomized control trial. So you randomly assign people -- and this is work that was done by Dr. Gastfriend and his colleagues.

If you randomize people to the recommended match by the ASAM decision rules, level of care placement guidelines, versus randomizing them to a mismatch going to, quote, the wrong level of care and seeing what happens, those that are matched to the appropriate level of care have better outcomes than the people who are matched to the inappropriate level of care using those specific ASAM directed guidelines.

Again, the kinds of outcomes that you would be clinically interested in; substance use, relapse, downstream hospitalization, functional outcome, and the like.

So a very, to me, persuasive body of evidence; A, that treatment matching can work; and, B, if you do it with the ASAM criteria, you're likely to get good results.

Q. Dr. Fishman, with regards to the empirical study of outcomes of ASAM matches versus mismatches, are you aware of any distinction in that study or the data about the superiority of ASAM matches over undermatches versus overmatches?

Do you understand what my question is?

A. Yes, I do. Let me just explain.

So you can get mismatched in two ways, right. You -- well, there are three possibilities. You get matched to the right level of care. You get mismatched to a lower level of

care, so undermatching. Or you get mismatched to a higher level of care. It'd be very interesting to compare those things.

The consistent result in all the studies I've seen is that undermatching is worse than appropriate matching. So if you go to a lower level of care than the level of care that's recommended by the decision rules for ASAM level of care matching, you do worse.

It's been somewhat more inconsistent. There are some studies that say overmatching does better for some subset of patients or for all the patients in a particular study. And there are other studies that don't say that overmatching is better than matching, but that matching might be better than overmatching.

But, again, the most consistent finding is that undermatching, mismatching down, always does worse than appropriately matching to the appropriate level of care.

And that's exactly the intention of the ASAM criteria is to find the right level of care, to get the best fit for effective treatment of a particular patient at a particular timing, of course, in their substance abuse disorder trajectory.

Q. Sure. You've mentioned a couple of times the six ASAM dimensions, the assessment dimensions.

Can you just list -- just list, please, what those six

dimensions are.

A. Sure. So, as I said, the ASAM method is to take this kind of broad comprehensive history and examination that a provider might do when meeting a patient who's entering substance use disorder.

You take a lot of data and you get information from the patients, you get information from their past history, you get information from concerned others. You try to put it all together.

And the ASAM six dimensions are just a particular way of organizing to make sure that the information is appropriately arranged in a way that will then facilitate the use of that information to assign -- to determine treatment needs and then to use them to make treatment-matching decisions.

So ASAM's organized it into six particular dimensions, that there's multidimensional assessment, that it's holistic, that is comprehensive; it's not just one track. Could it have been five? Could it have been seven? Sure.

But these six over time seems to have stood the test of time, and they are, 1 through 6:

Dimension 1, intoxication withdrawal potential. So is the person likely to have withdrawal? What will we need to do about it?

Dimension 2, biomedical complications and consequences. Will a person have a medical condition, either as a result of

the toxicity of substances or, preceding that, they might be made worse or affect treatment with the substance use disorders.

Dimension 3, emotional, behavioral, cognitive complications and conditions. That's kind of what we call co-occurring disorders or co-morbidity or dual diagnosis as someone from a mental hospital psychi- -- sorry, I apologize.

A person might have a psychiatric or a mental health problem that either preceded substance use or is caused by substance use or, more often, is intertwined with substance use, and that has implications for their treatment needs and their placement.

Dimension 4, treatment readiness. So that's about engaging patients and their motivation, where are they able to adequately utilize, what help will they need in progressing through the stages of change.

Dimension 5, relapse potential or continued use potential or continued problem potential. The likelihood that patients will use, will return to use, will relapse, and what should we do about that.

And, finally, Dimension 6, the recovery environment. Focusing on the home, the toxicity of a neighborhood or a family or exposure to substances and whether that's conducive to recovery and comports with successful treatment.

Q. Dr. Fishman, did you write an expert report setting forth

your opinions in this matter?

A. I did.

Q. And can you see what is marked for identification, Plaintiff Exhibit 881? Tell me if you recognize that as your principal report.

A. Yes.

Q. And if you turn to page 5, does that report contain a chart of the six ASAM assessment dimensions you just described?

A. Yes, they're there.

MR. GOELMAN: May I approach, Your Honor?

THE COURT: Sure.

BY MR. GOELMAN

Q. Showing you what has been marked for identification Trial Exhibit 881A. Is this nothing more than an enlargement of the six ASAM criteria assessment dimensions that's contained at page 5 of your report?

A. Yes.

MR. GOELMAN: With the Court's permission, I decided to go old school and just ask if he could come down off the stand and just walk through these dimensions in a little more detail using the easel.

THE COURT: Yeah, but you're going to put it over there so that I can see it and my law clerk can see it.

BY MR. GOELMAN:

Q. Dr. Fishman, can you come off the stand and review the six

dimensions in a bit little more detail.

A. Yeah. So I just wanted to highlight that it's important that the assessment of the patient and the translation of that assessment into treatment needs, needs to be multidimensional and needs to take into account at least these domains.

Again, the numbering of them and the ordering of them and the names used isn't the critical thing, but all this information is really essential to being able to make a level of care placement decision.

So just to go through them in order, Dimension 1 is about acute intoxication. Is the person currently experiencing or under the influence of substances, and what's the need that a patient has because of that.

And then what is the likelihood that a person will be in withdrawal. Either that they're sick now from withdrawal or that they're likely to go into withdrawal.

And then what kinds of treatment needs do they need. And then what kinds of level of care would that most effectively and appropriately be presented in?

And the reason it's numbered 1 is because, in a triage sense, there's a great deal of urgency to making acute intoxication determinations or the likelihood of an immediate need for withdrawal, which in some cases, although unusual, in some cases would be life-threatening. So that's number 1.

Number 2 is biomedical conditions and complications. This

has to do with what are the impacts on medical problems from substance use? Did a person have a liver problem? Did a person have an infection from their use?

Or did they have an ongoing chronic medical condition that substance use impacts and makes access to care difficult and impacts where care should be received, and what kinds of services will they need, and in what level of care will they need those services.

Dimension 3 is about mental health and psychiatric needs, emotional realm, behavioral realm, cognitive realm. And, again, just like in Dimension 2, they could be premorbid; that is, they could have had them before they were using substances. Depression, psychosis, trauma, and the like. And then their interactions with substances in a reciprocal way makes them worse. Or it could be that those emotional behavioral conditions were caused by substances, the toxic effects of intoxication over time.

But in either case, they're important, essential, that these co-occurring or co-morbid conditions be assessed. The question is how severe are they, what treatment needs, where would those best be done, and what level of care.

Dimension 4 is about stage of change, readiness to change. That includes acceptance of treatment, willingness to participate, motivation for treatment. But it also includes resistance to treatment, rejection of treatment, lack of

cooperation with treatment.

And different approaches are needed for patients at different stages of change, depending on what their self-assessment is, what their thought is about whether or not they have a problem and whether or not they think that problem is actually linked to substances. So that definitely impacts their treatment needs and where that treatment ought to be done, at what level of care.

Dimension 5 is about relapse or about continued use; that is, you have to have stopped to be able to relapse. Some people haven't stopped and they still have continued use.

Or not just continued use, but continued problems in other domains. So there's an interaction between the different levels. Might be a continued problem in a mental health domain. There might be a continued problem in a biomedical demain.

The idea is, what are the needs to attenuate, to stop, to prevent, return to problems or continuation of problems, and what levels of care would be most appropriate for the match.

And then, lastly, Dimension 6. Where does a patient live? What is the environment that is most conducive or most in opposition to their journey to recovery? And where should we be treating them in order to meet those treatment needs?

Are they in a setting in which there is endemic substance abuse? Is there a family that is supportive or in opposition?

Are there peers that are problematic or are supportive of recovery?

And so those are critical issues in determining level of care placement.

Q. Dr. Fishman, do the ASAM criteria dimensions purport to be in order of importance?

A. Well, it's not so much that they're in order of importance. Actually, in a clinical interaction with a patient, I sometimes am thinking that number 4 is the immediate therapeutic alliance issue.

How is it that you're engaging a person? How do you get them to think about approaching treatment and utilizing treatment and thinking about progressing along the stages of change?

But the reason that they're ordered this way is because dimension 1, if you're thinking about an emergency department or potential triaging of danger, relates to the possibility -- although relatively infrequent, relates to the possibility of danger and something that you need to do something about right away.

Same thing with a biomedical condition that could be of high lethality or very high morbidity or even mortality, say, if we're talking about an overdose. That's the thing that you want to zero in on because you need to move quickly.

Q. Does ASAM have a position on the need for practitioners to

consider each and every one of those six dimensions?

A. Absolutely. The notion is that, however you order them, however you name them, however you enumerate or catalog them, the content of each of these is essential to being able to do a comprehensive assessment, a comprehensive enumeration of treatment needs, and then using that as the basis for a level of care placement matching.

Q. And if deciding on a level of care placement without considering one or more of the dimensions listed there, is that a departure from the generally accepted standards of care?

A. I think it would be safe to say that you would not be meeting the generally accepted standard of care if you didn't include not just information gathering about these particular dimensions, or at least the content contained in these enumeration of dimensions, but if you didn't use each of them in establishing a treatment plan and in establishing a decision process for articulating and placing the patients in particular levels of care. Yes, that's right.

Q. Dr. Fishman, stay there.

Did your report also contain a chart of the ASAM levels of care?

A. Yes, it did.

Q. And is this, which has been marked for identification Trial Exhibit 881D, an enlargement of that table from your report?

A. Yes, it is. Can we swap out?

Q. Yeah.

A. All right.

Q. Can you describe to the Court what a level of care is?

A. So a level of care is a chunk, if you will, of a place or a program where treatment happens. So within a level of care, there may be various modalities that might include counseling or therapy or structure or activities or physician services or medication, a variety of different things, but they happen in a particular program. It might be a particular building or it might not. And they will have a variety of intensities.

The way ASAM catalogs it, mostly from Level 1 through 4 -- 1, 2, 3, 4 -- I'll mention very briefly in a second what 0.5 is -- that you can think of levels of care as proceeding from most intensive or least intensive or least intensive to most intensive. And they'll be recognized by most people as being the general catalog.

There might be some particulars of the way ASAM catalogs it that give particular meaning and, in my view, enriches the meaning, but they're -- whether it's numbered this way or some other way, they're relatively easily recognized by people.

And so the idea is that, at the most intensive level of care, as ASAM calls it, level 4, we're thinking about a hospital. We call that medically managed intensive inpatient.

Medically managed, because all of the treatment or the

core of the treatment is not just supervised and directed by clinicians, but -- and other medical personnel such as P.A.s, M.P.s, nurses and the like, but that it is actually carried out by medical personnel.

And so it's a setting in which the highest intensity of medical services might be needed. That includes oxygen coming out of the walls and IV drips being accessible, and intensive care units on floor 6 and an OR with surgeons being available for consultations.

It's for the most extreme, most medically dangerous, most intensive needs. It's a restrictive setting that's required. In some circumstances tends to be more short-term.

The next kind of broad levels are the residential levels. Those are also defined by being bed-based; people sleep there. I'll break it down into a second, to the sub levels, 3.1, 3.3, 3.5, and 3.7.

But the core features of a residential treatment is that it's a place where a person needs to be sequestered, mostly away from the community, have additional structure because the community isn't an effective place to conduct the treatment, it wouldn't go well, and that it bring certain advantages.

It brings separation. It brings an intensity of dose. It brings a bundling of a bunch of services together that might be hard to do in a smorgasbord where you'd have to go to different programs and have a schedule of Tuesday here and Thursday there

and a half hour there. It's all in an intensive dose where it's available.

And within Level 3, there is this gradation from more intensive levels of care to lower intensive residential levels of care. The ASAM catalog is that 3.7 refers to medically-monitored, high-intensity residential.

Medically-monitored means that medical staff -- doctors, nurses, et cetera -- are available. They are involved in supervising and directing the care even if they don't deliver every aspect of the care in the same way that it's done in a hospital.

So, for example, you might not see a doctor or a nurse every day, but they're available. Might be 24/7 nursing as needed. Doctors create a treatment plan and direct the care and are available for intermittent delivery of the care when needed, but it's somewhat less intensive.

3.5, and I'll talk about adults first, is the next level of residential care. It's called clinically-managed, high-intensity. Again, it's high dose. There's a lot of activity. There's a lot of structure.

We tend to think of 30'ish hours of clinically-directed services, say in this level of care, maybe somewhat fewer in this level of care. But the main difference is that, here, the level -- the services are directed and supervised by medical staff.

In 3.5 that's not required. That is, we have the expectation that other professionals -- therapists, counselors, nonmedical staff -- are directing the care, are supervising the care, are delivering the care, and that in this level of care you wouldn't need 24-hour nursing. You wouldn't need the availability of a bunch of doctors, addictionologists, psychiatrists, because those wouldn't be appropriate.

If we were here or here (indicating) it would be more about the therapeutic review, about the structure, about the frequency of the therapies that you're getting at a psychosocial level, not so much about the medical interventions.

Notice that for adolescents we don't talk about the high-intensity clinically-managed. We talk about the medium intensity of clinical management, and that's because adolescents -- and we can talk about this a little bit more in detail later -- have different developmental needs and sometimes are not as -- would not benefit as much from the higher intensity at this level of care but might need a longer duration at a medium intensity for their particular developmental needs.

3.3 is a kind of level of care that is somewhat similar to 3.5. Again, it's clinically managed, but it's population-focused in the sense that patients that have special needs having to do with not being able to as quickly absorb the

high intensity of a residential treatment might need a longer duration.

Those might include patients with severe co-occurring disorders, cognitive impairment that might come even from preexisting conditions or from the toxicity of substances, head injuries and the like. They don't absorb it as slowly, they need more repetition, they need longer durations of care.

One thing that's important to think about as we go down through intensity is that durations tend to increase. Less duration, the highest intensity; longer durations, the lowest intensity.

Q. Dr. Fishman, can I just interrupt? You said, I think, that they don't absorb it as slowly. Did you mean they don't absorb it as quickly?

A. I meant as quickly, my apologies. Thank you for catching that.

Q. Thank you.

A. And then the last, lowest-intensity residential level of care is 3.1, clinically-managed low-intensity residential. And that's a very important and, I think, vital component of the continuum of care in residential treatment.

And that is, although structure is provided and the possibility of a safe refuge and separation from the community is provided, there's also a great deal of focus on integration into the community.

So a patient might stay there for longer periods of time and still not just stay 24/7 in the residential treatment, but go out during the day to work or to school, even to an outpatient program down the street or across town to be able to mix and match clinical levels of care across different components of the continuum.

And so this is a way, if you will, of testing the waters and doing community integration for longer periods of time for patients that may need that extra support and longer periods of time to consolidate recovery gains that they were not able to consolidate elsewhere.

Level 2 is intensive outpatient. Level 1 is outpatient. The distinction is in terms of frequency of contact hours, the number of hours per week, the number of days per week that a person might need treatment contacts.

So in Level 2, there's two sub levels. 2.1 is intensive outpatient. 2.5 is partial hospital. In 2.1, we tend to think, for adults, of about nine hours -- contact hours per week. For adolescents, maybe six hours of contact hours per week.

Typically, somebody would go to get treatment two or three or four times per week, so the need of several contacts per week to get monitoring and intensity of dose such that, although there is adequate, effective and safe supervision in a home environment, because they're not sleeping here, they need

more intensity to progress them through to the journey of recovery.

And 2.5, even more contact hours. We tend to think of it as about 20 hours contact per week with daily or near daily. Some might have weekend hours. Some might need Monday through Friday. But the sense is you go in every day, that you can maybe be safe and supported in your recovery effort at home for a brief time, but then you're quick back to be able to get a therapeutic benefit.

Outpatient is a broad range of everything else; that is, a couple times a week, one time a week, once every two weeks, once every month, once every three months. For somebody who's really, really stable, years later perhaps.

But the idea is that you're typically going to see a practitioner. That practitioner could be a therapist, could be a counselor, could be a group, could be a combination of those things, but it's a lower intensity.

It's not as much requiring what we call the milieu or the organized service with a group of peers and a group of staff that provide more than the individual interactions but which provide, kind of, a support network and an atmosphere of recovery.

Some patients may start here and progress up because they don't do well and they need more. Other patients may start here and, as they taper down or step down, they progress in

this direction.

One of the things that is so important about a continuum of care with this full expression of different levels is that many patients have twists and turns and there isn't, kind of, a linear progression or one archetypical path, but that patients might lapse, might do well.

This is a chronic disorder with a chronic vulnerability. It's remitting and relaxing. It's waxing and waning. What we hope for in generally accepted standards of care is that people can flexibly move up and down a way that's adapted to their particular needs. And one time in their course they may be here, another time they might be here, and they might move back and forth in that way.

Just real quickly, intervention is like a DUI program for patients that may not yet have been declared or diagnosed to have a full-level disorder but might need monitoring or prevention to help progress further development, needing full treatment at one of these levels of care if they were to develop a disorder later, but it's before they've developed the first disorder.

Say they've had one or two consequences of dangerous use, like a DUI program.

Q. Thank you, Dr. Fishman. If you can resume the stand, please.

A. Yeah.

Q. How does the ASAM system with the levels of care work with the ASAM assessment dimensions that you went through before, together, to determine the appropriate treatment placement for particular patients?

A. So you start with an assessment, and what is the patient's severity in each of the six dimensions, thinking multidimensionally and comprehensively. Translate that into treatment needs.

What are the kinds of treatments? What are their problems? How would you put that together in an overarching treatment plan?

And then, finally, how do you translate that into a placement level of care? Where should they get that treatment? It's kind of the question of who goes where at what time in their course.

Imagine, if you will, a grid or a matrix with assessment dimensions down the left side, levels of care across the top. And you could see in each dimension a place where that treatment need could be provided, a particular level of care.

And you see that for assessment in Dimension 1 and treatment needs and matching in Dimension 1. You proceed with 2, 3, 4, 5, 6. And then you put that together in a recipe that says, ah, the best place to get at all of those six assessment dimensions and the ensuing treatment needs is in that particular level of care, whether it's Level 1, Level 2, Level

3, Level 4.

Q. Who are the intended users of the ASAM criteria, Dr. Fishman?

A. Well, it might be anybody intending to try to determine where a patient is best treated. It might be an addiction physician. It might be a counselor. It might be a treatment program. It might be a payor. It might be a utilization management care reviewer. It might be a policymaker or a government official trying to make a resource allocation decision or design a treatment continuum of care.

It's really intended to be quite broadly applicable to all situations across the spectrum where SUD treatment is done.

Q. Are the ASAM criteria intended to replace the use of clinical judgment by providers?

A. No, not at all. This can't be done, I think, by robots as well as it can be done by people with training and experience and knowing how to take care of patient.

So clinical judgment is a requirement for being able to carry out the treatment, for being able to think through the exercise of where a person should get treatment and where it's most likely to be effective.

But, on the other hand, it does need a framework. And so clinical judgment for this particular task, that is, level of care placement, is best exercised within these guidelines. And it's giving a broad structure.

Clinical judgment helps implement it. Clinical judgment helps work on the gray areas. Clinical judgment helps resolve conflicts where perhaps the decision rules don't resolve them to the tenth decimal place. So they go hand and hand in there synergistically.

Q. Dr. Fishman, when you were engaged by plaintiffs in this matter, what were you asked to do?

A. I was asked to give an opinion as to whether the UBH utilization management criteria were consistent with generally accepted standards of care.

Q. Was that relevant to the years 2011 to 2017?

A. Yes, those years.

THE COURT: And we'll get to that critical question in ten minutes.

(Laughter)

THE COURT: Thank you.

(Recess taken at 10:45 a.m.)

(Proceedings resumed at 11:08 a.m.)

THE CLERK: Dr. Fishman, you're still under oath.

THE COURT: Go ahead.

Have a seat, please.

BY MR. GOELMAN:

Q. Dr. Fishman, as part of your work in this case, did you review the UBH Level of Care Guidelines for the years 2011 to 2017?

A. I did.
Q. And when you did that, did you pay any particular attention to any particular provisions?
A. Yes. I was looking specifically at the Substance Use Disorder Treatment Guidelines.
Q. Okay. Were you also looking at something called "Common Criteria" that apply to all types of diagnoses?
A. Yes, I was.
Q. And based on your review of the Level of Care Guidelines and on your professional experience and background, did you reach any conclusions or opinions about whether the Level of Care Guidelines comport with the generally accepted standards of care?
A. Yes, I did. It's my opinion that the UBH guidelines are not consistent with the generally accepted standards of care for placement level of care treatment matching.
Q. Is that for all seven years that you looked at?
A. That is for all seven years.
Q. Were there changes in the guidelines occasionally from year to year?
A. Yes, there were changes. From the first iteration that I looked at through 2017, I thought that there were some things that got better, some things that got worse; but overall, those things didn't change my conclusion, and I thought in each of those years in their totality the UBH guidelines were not

consistent with generally accepted standards of care.

Q. Before we turn to the guidelines themselves, can you please just summarize the ways that in your opinion they fail to comport with the generally accepted standards of care?

A. Sure. So the big picture is that I think the UBH criteria are overly restrictive, and by that I mean that they restrict access to needed care at various different levels of care. I think they do so more at the higher levels of care, residential, but they do so throughout, including outpatient.

And the notion is that what we want from a level of care placement matching guideline are decision rules that direct a user to place a patient where the treatment will be most effective, where the outcomes will be best, where their journey of recovery will likely be aided in the most successful way.

And I think that what the UBH guidelines do is, both by restricting admission or restricting continued stay or by promoting discharge in an appropriate way, their decision rules are overly restrictive.

There are a couple of particulars that I think add up in their totality to that conclusion. One is that there is an inordinate, in my view, overemphasis on looking for acuity in determining why patients should get admitted and should stay in particular levels of care.

And by that I mean what are the emergencies? What are the crisis-driven, precipitous reasons for admission? And although

those are certainly important, I think they are overemphasized; and I think that matters of enduring severity, matters of chronic severity, matters of cumulative severity are underemphasized and not taken into account adequately.

Certainly, patients come to treatment with a problem that is here and now. They may have a pressing reason why today, but that isn't the only thing that should be considered. And I think that patients may have long histories in this chronic condition that is remitting relapsing in which severity can be cumulative over time, and I think that that's not taken adequately into account.

One particular set of criteria within the UBH criteria that I think highlight that is in later years you see a concept of the "why now" factors. Those emerged, I think, in 2013 and 2014, and they are one particularly strong way of articulating this focus, in my view and overemphasized focus, on acuity and on crisis.

So patients should be admitted almost with exclusive emphasis and continued to be treated with inordinate emphasis on the precipitating problems that are the crisis and why they came into treatment. And once those are resolved or addressed, there's not as much emphasis on other things that may be problems that are enduring, problems that have emerged, or other ways in which patients continue to need to need treatment for ongoing recovery.

And there are years where "why now" is not used, but then language like "presenting problems" or "the reason for admission" replace it, and the concept I think is an enduring one over the years.

Another concern I have is that I think that there is inordinate emphasis on imminent danger or severe danger or severe harm as a criteria for and requirement for admission and for continued stay.

So there are, for example, numerous occasions in which the criteria say that in considering a lower level of care, we would go instead to a higher level of care because in the lower level of care, a patient wouldn't be safe or the treatment couldn't proceed safely or safety wouldn't be met. Certainly that's important, but I think there is an underemphasis on the congruent -- the concurrent -- what I would think would be a need for emphasis on concurrent effectiveness, not just safety.

There's language such as "the problems endanger" -- "the problems threaten the patient's safety" or "the welfare of the patient is endangered"; and although there's no one instance that is maybe greater, in the totality, in the aggregate I think this overemphasis on concerns about dangerousness and safety add up to a narrow focus rather than considering other factors, such as where treatment should be most effective.

Not that risk is not important. So, for example, the ASAM criteria certainly consider risk. One of the phrases that the

ASAM criteria use to consider risk is the phrase "imminent harm"; but there's a much broader definition or should be a much broader definition, in my view, in generally accepted standards of care of what the metric of risk ought to be.

The metric of risk ought to be one not just of high lethality or grievous bodily harm or danger to life and limb. It ought to be risk of relapse, imminent relapse, or risk of continued problems or risk of impairment in function or risk of other difficulties that stand in the way of a patient's treatment needs.

Q. Dr. Fishman, can I interrupt for a moment?

A. Yeah.

Q. When you were describing the ASAM dimensions, the assessment dimensions --

A. Yes.

Q. -- did categories 2 and 3 of those dimensions involve something that could be labeled comorbidity?

A. Yes. I think that those are things that for me are concerning in their omission in the UBH criteria. I was talking about some things that are in the UBH criteria that I think are problematic, but I also think that the UBH criteria underemphasize consideration of comorbid medical conditions and comorbid mental health or psychiatric conditions in making decision determinations about where patients should be placed.

I also think that there is in the UBH criteria the

absence -- again another issue of omission -- of separate criteria for adolescents and young adults, for young people. I mentioned it very briefly, but I'll just emphasize again that adolescents have a different set of needs, they have different assets and vulnerabilities. The kinds of treatment, there may be some aspects that do overlap with the adult needs but there are aspects that are different, and so at some times they may need more intensity, at other times they may need less intensity. Most often they will need longer duration of treatment than adults.

And so I find it problematic and inconsistent with generally accepted standards of care that the UBH criteria don't have separate criteria for adolescents.

Q. Dr. Fishman, you summarized your conclusions, your opinions, but can we talk for a minute about your process? How did you go about evaluating whether the UBH Level of Care Guidelines are or were consistent with generally accepted standards of care?

A. Well, I read through them and used the words of the guidelines as prescriptions for how a user would make decisions about who is recommended to go to what level of care at admission, at continued stay, at discharge, and then compared those with my understanding of the generally accepted standards of care and saw that they were inconsistent.

Q. And is your opinion that they're inconsistent based on any

isolated use of a particular phrase or word in the guidelines?

A. Well, I think there are some phrases that are more problematic than others, but there is no one word. It isn't a matter of better line editing or wordsmithing. It's that each of these individual criterions -- criteria come together to form a whole. And in all the ways that I mentioned -- and maybe some we'll talk in more detail -- they are mutually reinforcing and form an atmosphere of restrictiveness; but more important than the atmosphere, they are directions in aggregate to limit the pathways of access to particular levels of care for particular patients.

So we would want to see -- in guidelines that met the generally accepted standard of care, we'd want to see multiple different pathways for multiple different possible patients; and one patient might meet number -- criteria one and number three, another patient might meet number one and number seven or two and five. But what the UBH criteria create, I think, is a narrowing of possible pathways in such that at the end of the day, access is restricted.

Q. Dr. Fishman, I want to begin by directing you to the 2015 Level of Care Guidelines.

A. Okay.

Q. And they're already in evidence. They're Exhibit 5. And you have, I believe, a binder of the guidelines. If you're more comfortable using the paper copy, that's fine, otherwise

we can also put particular pages on the screen.
A. Either is fine. I'll start with paper.
Q. Okay. Can you turn, please, to page 8 of the 2015 guidelines, page 8 internally. It's also Bates stamped Trial Exhibit 5-0008.
A. Yeah, I see that.
Q. And there's a heading there entitled "Common Criteria." Do you see that?
A. I do.
Q. What is your understanding of what common criteria are?
A. So later on in the guidelines there are particular guidelines for individual levels of care with specific material appropriate to that level of care -- outpatient, intensive outpatient, residential -- but these common criteria are material that is subsumed and contained in all levels of care. So it's material that you would apply no matter which level of care you were looking at, and you would include that and then add the level-of-care specific material.
Q. Okay. And are there -- is this section itself broken up into subsections for admission criteria, continued care criteria, discharge criteria, and best practices?
A. Yeah. That's the way it's organized here.
Q. All right. Let's start with the admission criteria.
A. Okay.
Q. What is your understanding of the purpose of this section?

A. So admission criteria are at the outset what are the criteria based on which you would determine treatment needs that would direct a user to admit a person or to approve benefits for a person for this particular -- a particular level of care at the outset.

Q. Okay. And you see that there's Sections 1.1 through 1.9?

A. I do.

Q. And that there is in all caps, underlined the word "and" in between those sections?

A. Yes, I do.

Q. Is it your understanding that if someone fails to meet any one of these criteria, they never get in the door, they're never admitted?

A. Yeah, that's right. They need to meet each of these to meet the overall criteria of getting into a particular level of care, correct.

Q. And can you please direct the Court to any of the provisions in this section, the admission criteria, that contributed to your conclusion that the UBH guidelines violated the generally accepted standards of care?

A. Well, so both 1.4 and 1.5 are examples of what I briefly mentioned before as the articulation of the "why now" concept and the -- and what I believe is the overemphasis on "why now."

So that 1.4 is about why a lower level of care would not be safe or efficient or effective; and 1.5 is about why a

current level would be safe, efficient, or effective. But in both circumstances, the metric, the way in which the user is directed to follow the instructions to make that determination is to assess whether acute changes in the member's signs and symptoms and/or psychosocial and environmental factors -- that is, the "why now" factors leading to admission -- are meeting that severity.

And as I briefly mentioned before, I think that such "why now" factors or acute changes or the moment's crisis that precipitated a particular admission, those are certainly important things and those should go into the decision, but I think they are necessary but not sufficient.

And I think to drive the user to focus there with this over -- in my view, overemphasis is by omission not to direct the user to review more chronic factors, more enduring factors that may or may not have been the last thing that got the person in. If you will, in some cases there might be a straw that broke the camel's back. It might be the last thing that drew the person into treatment: His spouse threatened to throw him out, his employer threatened to fire him, his doctor told him that he had a medical condition. I mean, there may be all sorts of different kinds of things that are acute precipitants and those are important, but there might be many other kinds of enduring issues of greater chronicity that contribute cumulative severity that I think are underemphasized with this

emphasis on "why now."

THE COURT: So wait a second. You said necessary but not sufficient? Did you mean that? You said that acuity may be a necessary but not sufficient --

THE WITNESS: Well, I mean it's necessary to consider it.

THE COURT: Okay. But then you don't mean it's necessary but not sufficient?

THE WITNESS: Fair enough. Thank you.

BY MR. GOELMAN:

Q. Dr. Fishman, before we leave 1.4, do you see Section 1.4.1?

A. I do.

Q. And do you have an opinion about that particular subsection?

A. Well, so this is an explicit rejection of what we call a fail first criteria. So "fail first" means that in order to gain access to a particular level of care, you must have demonstrated participating in, attending a lower level of care, and failing as a reason to need the higher level of care. And that certainly is not consistent with generally accepted standards of care, and here it's explicitly said that it's not required by the UBH criteria.

Q. And in your review of the Level of Care Guidelines for other years, did you notice whether this phrase or other

contradictory clauses were included?

A. So here in this year in the common criteria it's explicitly rejected. I think there are places in other years where it is included and fail first is a requirement, yes.

Q. So is this one of the ways you testified that the guidelines sometimes got a bit better, sometimes got a bit worse? Is this one of the ways that they got better in later years?

A. Yeah, this is better. It is appropriate to reject this. In other years, there was fail first.

Q. Okay. Can you turn to 1.6, please.

A. Yes.

Q. You were testifying about comorbidities.

A. Uh-huh.

Q. Is that the subject of this section?

A. It is. And while I certainly like that it is mentioned as a factor, so it's not never mentioned, here it's mentioned as a way of assuring that they are not too severe to be managed at this level of care.

So we would want co-occurring psychiatric problems, mental health problems, or co-occurring medical conditions to be able to be safely managed in this level of care; but what's missing is that their severity would get you access to the particular level of care because the treatment needs in a behavioral health or a medical condition were of a sufficient severity to

require this level of care.

So they are exclusionary here for being too severe, which is fine, but there's nothing that is permissive about why such comorbid conditions would get you into a particular level of care.

Q. Okay. Let's turn now to one point --

THE COURT: I don't understand that distinction. Explain to me that distinction. If something is -- if a comorbid condition cannot be safely managed at a lower level of care, then it's sufficient to get you into the higher level of care?

THE WITNESS: Right, but it may not be enough, and that's not exactly what this says, but it may not be enough that it's just not safe at a lower level of care. I would want it that if it wasn't effective at a lower level of care, it would bump you up because just being safe is not enough, in my view. You want the best outcome and the more effective treatment.

Here, this is to say that we will let you into this level of care if it can be safely managed, otherwise you would need to be in a higher level of care yet because it's unsafe at this level of care; but what's missing for me is a guide to the user as to why you'd need this level of care to meet the needs of that co-occurring disorder, not just to exclude it.

THE COURT: Okay. I'm not sure that's clear, but --

THE WITNESS: Okay. Sorry.

BY MR. GOELMAN:

Q. Can you turn to 1.8, please, which deals with the requirement that there be a reasonable expectation of improvement in the patient's condition.

A. Yes. So this is an example of an area that comes up repeatedly throughout the criteria, and it's this notion of an expectation of improvement, which on its face is not a problem. It's a matter of how that's defined.

There is a distinction that's drawn by the UBH criteria and attention between the concept of active treatment and custodial care. So treatment is supposed to be active in order for it to be allowed.

Custodial care, which is, to cartoon it, just babysitting, is to be excluded. And while that's a reasonable concept, I think that the UBH criteria overly narrowly define what is "active treatment" and overly broadly define what is "custodial care."

And, again, those words aren't used here, but it's a similar concept in here that improvement of the member's condition is indicated by a reduction or control -- this is 1.8.1 -- of the acute signs and symptoms that necessitated treatment at a level of care; and in my view, that's too restrictive on only the acuity, on only the crisis and not looking at a broader view of improvement in more chronic

conditions as well.

I also have some trouble with the focus on the reasonable period of time. Not that I'm looking for an unreasonable period of time. It's that without an operationalization, which we don't have, I think that that directs the user to the notion that the clock is ticking; and that if it takes too long, that under scrutiny, that's a problem.

Q. And, Dr. Fishman, in 1.8.2, it says "improvement in this context." Do you see that?

A. I do.

Q. And is your understanding of the phrase "in this context" in the context of the reduction or control of the acute signs and symptoms?

A. Well, so in contrasting active treatment with nonactive treatment or with custodial -- with custodial care or looking for improvement, the generally accepted standard of care includes an improvement, the prevention of deterioration, and also the maintenance of an existing level of function.

And although there is -- the hat is tipped here in 1.8.2 to that, it says that improvement in this context is measured by considering prevention of deterioration; and the context that we're in in 1.8.1 above is a reduction or control of the acute signs and symptoms.

So it's prevention of deterioration, to the extent that it's considered, is prevention of deterioration in acute signs

and symptoms but not prevention of deterioration or maintenance of function in broader, overall function and of prevention of deterioration in more chronic problems.

Q. And is -- the language in 1.8.2, do you recognize it as being drawn from any outside source, or at least portions of it?

A. Well, this general concept comes, I think, from the CMS Guidelines for care determination, and there it's not limited to the context of acute signs and symptoms, but it's more broadly stated to pertain overall to include prevention of deterioration and maintenance of function.

Q. And the CMS Guidelines, those are for Medicare, the government guidelines?

A. That's right. So CMS, the Center for Medicaid and Medicare, issues a variety of instructions to the field that become the -- are incorporated into the standard of care in a whole host of ways, and this is one of them.

Q. Okay. Do you recall if there's any language in the CMS Guideline relevant to this that has been omitted from the UBH version?

A. Well, it doesn't focus on the maintenance of function, and in the CMS Guidelines, it does not focus on acute signs and symptoms in the way that it does here, that's correct.

Q. Okay. Let's turn to --

THE COURT: Well, let me ask you about that. 1.8.2, I

don't understand why you think that focuses on acute. The word "acute" doesn't appear anywhere in 1.8.2. This context, if anything, would appear to refer to 1.8, which also doesn't refer to "acute."

The last sentence suggests that the measurement in 1.8.2 is broader than just acute. Why do you -- how do you get out of 1.8.2 that they're not measuring -- that they're measuring improvement with an overemphasis on 1.8.2 in 1.8.2 of acute care?

THE WITNESS: Well, my interpretation is that 1.8.1 instructs us to do a measure of improvement by reduction of acute signs and symptoms and that that's continued into 1.8.2.

And in the CMS language --

THE COURT: How do you make sense of the last sentence of 1.8.2 then?

THE WITNESS: Well, I'm glad that that's there, and I do think that we're indicating -- we're asked to look at recovery, resilience, and well-being, but I'm concerned that the metric --

THE COURT: Isn't that broader than just the indication in reduction or control of acute signs?

THE WITNESS: Yeah, it would be, and I would want it to be.

THE COURT: So 1.8.2 is broader than just looking for improvement at acute. Wouldn't you have to reach that

conclusion?

THE WITNESS: Well, there's a tension and a contradiction, so I'm concerned by where the user is driven to focus on "acute."

THE COURT: Okay.

BY MR. GOELMAN:

Q. Let's turn to the continued service criteria, which is Section 2.

A. Uh-huh.

Q. 2.1 says that the admission criteria continue to be met and active treatment is being provided, and then has a definition of "active services." Do you see that?

A. I do.

Q. Can you -- do you have an opinion as to whether Section 2, in particular 2.1, is consistent with the generally accepted standards of care or itself leads to overly restrictive standards for treatment?

A. Well, I think consistent with the admission criteria, that the focus on "why now," that is the focus of treatment that the admission criteria continue to be met again, for me overemphasizes these acute factors to the exclusion of more chronic and cumulative severity.

Q. And do you see the appearance of the "why now" language in 2.1 anywhere or 2.22?

A. Yeah, it's in 2.1.2, it's in 2.2, and the user is drawn

repeatedly to make their almost exclusive concern be those things; and what is omitted is looking at the possibility of newly emerging problems, of concurrent and enduring chronic problems that may not have been the crisis precipitant and for other problems that would continue to be addressed in a broader way, not just this narrow way.

Q. Dr. Fishman, before we move on to the discharge criteria, what is your understanding of the impact of the failure of a patient to meet any single one of the continued service criteria in Section 2?

A. Well, all of these need to be met in order to sustain service. So if one is not met, the patient is to be discharged.

Q. Okay. And can you look now at the discharge criteria?

A. Yes.

Q. And can you undertake the same exercise there, identify those sections that contributed to your opinion in this case?

A. Yeah. So the continued stay criteria are no longer met. Just what we've just said, if those don't continue to pertain, a patient should be discharged. And here are some examples, and they are examples so they are not requirements and they are not necessarily an exhaustive list but they are the ones that are listed here, and this is where the user is focused to kind of do the mental checklist.

And, again, I think there's an overemphasis on "why now."

In 3.1.1, as I've said before, we're talking about safe transition, which is important, but I think it also has to be safe and effective transition. And I think that there should be examples of other than "why now" factors -- "why now" considerations being met.

Q. Okay. This discharge criteria, this is a list of examples, a not exhaustive list; correct?

A. Yes, that's right.

Q. Can you turn to 3.1.5, please.

A. Yeah. This is another example that for me is problematic. Here it gets at this issue of an overemphasized -- overemphasis on the need for motivation and whether or not a patient in what ASAM calls Dimension 4 is cooperative and participating and going along in an eager way with the treatment goals.

And I think that it is not appropriate or consistent with generally accepted standards of care to discharge a person for lack of motivation or for unwillingness to participate. In fact, sometimes it's lack of motivation or reluctance or even frank opposition to treatment that requires a certain intensity of treatment to get to persuade them to get with the program and to do better and to become cooperative and to become motivated; and that's really the responsibility of the treatment program, to ask people to be highly motivated at the door.

And we'll come back to this, I think, in other examples

throughout the criteria. To ask people to be motivated at the door is to ask people to be well before they get into treatment. I don't think it's reasonable to discharge people for uncooperation. I mean, unless it's dangerous uncooperation.

Q. What does the generally accepted standard of care say about what you should do about if someone is unmotivated? Do you lock them up and force them to undergo treatment?

A. No, no, and that's an unreasonable juxtaposition here and sets a very high standard, I think, of what we might do in a parentalistic way for somebody who's unwilling to participate. Involuntary treatment or guardianship requires that the person, you know, meets the regulatory standard for involuntary civil commitment in a hospital. Guardianship requires the demonstration of incompetence at a very high level of evidence.

There's lots of gray in between being unwilling to participate or unable to participate where the standard of care would be that the provider would be to try to persuade them and cajole them and to help them digest and to work with them in what we call motivational enhancement treatment to get them to try to participate short of needing involuntary treatment or guardianship.

Q. Dr. Fishman, in your 25 years of practice in the substance use disorder field, have you had the experience that sometimes people with very serious substance use disorders don't believe

that they have a problem or need treatment?

A. Absolutely. It's part of the hallmark of this disorder, that it robs people of their insight and that motivation tends to be low. To expect otherwise, is to set ourselves up for failure.

Most people come to treatment not necessarily seeing the impairment, having low self-recognition of problem, and not making the connection between even their most acute and dangerous problems to substance use, never mind their more chronic and indolent problems.

And we sometimes call that an early stage or change or precontemplation; and to get them through to contemplation and preparation and action, which is some of the jargon we use for the stages of change, is part of the expectation of treatment.

This is a chronic disorder in which people's ability to recognize that focusing on quitting is good for their health is problematic. And even if they recognize that focusing on quitting is good for their health, they are ambivalent at best often because the problem with substances, one of the core mechanisms of an addiction is that the substances are so good, but in a maladaptive and dangerous kind of way, at motivating the patient that they divert patients from what we would think to be their more healthful motivation.

And so, again, to discharge them prematurely for lack of motivation or lack of cooperation I think is inconsistent with

the generally accepted standard of care.

Q. Dr. Fishman, I'm turning now to the next section, which is captioned "Clinical Best Practices." Is there anything different about this section as compared to the previous three?

A. This section is less about decision rules and about the approach to making treatment level of care matching decisions than it is about instructions to the provider, say, about how to gather assessment information or about what topics to broadly and generally take into consideration, and guides more of the various different subcomponents of treatment wherever they might be delivered at any particular level of care. And they are essentially directions to the provider less than they are directions to the care manager or to the payer or to the user of the manual for making a decision about where the person goes.

Q. Is there anything in the clinical best practices section that overrules the criteria for admission, continued service, and discharge that you just went through the previous three sections?

A. No, none that I've identified.

Q. So if a particular --

A. The other way around, in fact.

Q. What do you mean?

A. Well, I mean that it would -- I think the decision instructions in the other sections where the actual decision

rules for level of care placement are what I believe overrule the clinical best practices.

Q. Now, you talked earlier about your opinion that the treatment of custodial care by UBH was overly broad and the definition of "active treatment" was overly narrow. Can you turn to Trial Exhibit 148 in evidence, which is the 2015 Custodial Care and Inpatient Residential Service CDG? Is that up there?

A. It is on the screen and I have it on paper.

Q. Can you turn to the first substantive page, which says "Key Points" at the top?

A. I see that. It's page 2 of 8.

Q. Yeah. And in bold it says (reading):

> "Services provided in psychiatric inpatient and residential treatment settings that are not active and are solely for the purpose of custodial care as defined below are excluded."

Do you see that?

A. I do.

Q. And does -- the term "psychiatric inpatient and residential treatment settings," does that correspond to any of the levels of care in ASAM that you reviewed earlier?

A. Not exactly. Much of this material is taken actually from psychiatric inpatient or hospital care guidelines.

Q. Okay. Is there anything about the criteria here for

defining "custodial care" -- well, withdrawn.

What is your understanding of what an exclusion is in insurance jargon?

A. Well, so here in particular, or with any factor, if a certain criteria is met, then the coverage is excluded: The admission, the continued stay. And here it's if the treatment is deemed to be solely for the purpose of what is being defined as custodial care, then the coverage would be excluded.

I would add that elsewhere they talk about -- the criteria talk about being primarily for the purpose of custodial care being excluded, but it's the same concept.

Q. Okay. And anything about this definition of "custodial care," Dr. Fishman, that is in your opinion inconsistent with generally accepted standards of care?

A. Well, one thing that I think is, just to step back a second, important to think about in the way in which the UBH criteria by omission do not meet generally accepted standard of care is that they don't consider broadly the full continuum, in my view, of residential levels of care.

So before we talked about 3.7, 3.5, 3.3, and 3.1, and in my view the way that the UBH criteria are written is that they focus on the medically monitored highest levels of residential care and don't do adequate justice to including criteria that consider the lower levels of care -- 3.5, 3.3, and especially 3.1.

And here's an example of that. In the second main bullet, the third subbullet, "custodial care" includes a definition of services that do not require continued administration by trained medical personnel. And that certainly should not be a requirement by generally accepted standards of care for the lower levels of residential care.

In a Level 4 hospital or a Level 3.7 medically monitored residential setting, there could be the need for medical personnel to administer certain services. But in 3.5, 3.3, 3.1, the lower levels of residential care, that would not be a reasonable requirement. Those levels of care are explicitly for services that don't require medical personnel to deliver the services at all.

MR. GOELMAN: Can you put up the active treatment definition, please.

Q. This section purports to cite to the CMS determinations, I think twice it cites that, including the CMS Benefit Policy Manual. Dr. Fishman, if something is in a CMS Manual, how could it be inconsistent with the generally accepted standards of care?

A. Well, the citation here is to the psychiatric inpatient coverage determinations and so, for example, in the subbullet that describes that active treatment is indicated by services that are all of the following, where it says it must be supervised and evaluated by a physician, that might be

appropriate for a hospital but it would not be appropriate for lower levels of residential care where they are clinically managed, not medically managed or medically monitored, and would not be under the supervision or evaluation or even monitoring of a physician. And so if that excludes that -- all of those services, that, for me, is an overly broad definition of "custodial care."

Q. Okay. Well, just taking a step back from language and considering practical consequences, what would the practical consequences be of the mismatching of the criteria for higher level of residential care with patients who would be appropriately placed in the lower levels of residential care?

A. Well, I don't think that this would get patients into higher levels of care. I think it would -- because they may not meet criteria, but it sets the requirement that they be in higher levels of care.

So could you rephrase the question?

Q. Yeah. That was a poor question.

If a patient qualified for residential treatment under 3.1 or 3.5 --

A. Yes.

Q. -- but not under 3.7, under this guideline, would that patient get any kind of residential treatment?

A. I understand.

No, they wouldn't because the services could be construed

as not being administered, supervised, evaluated, directed by a physician, and that they might be deemed to be custodial care, especially when we're talking about this question that we were talking about before of the metric of acute changes and the metric of what I consider to be reasonable prevention of deterioration and maintenance of a level of function.

Q. Dr. Fishman, up to this point the guidelines that I have shown you have been applicable to both mental health and substance abuse conditions. I want to turn back to the 2015 Levels of Care Guidelines and explore some of the language that is specific to substance use disorder.

A. If you don't mind, can I just make one more comment?

Q. Oh, sure.

MR. GOELMAN: Can you put 148 back up, please.

THE WITNESS: At the bottom here, the second-to-last main bullet and its subbullet in which the language of improvement looking at and considering prevention of deterioration here seems more clearly subsumed under the stem bullet above it where the metric is the reduction or control of the acute symptoms.

And so, again, I just want to emphasize that I see here those things intertwined and the emphasis on reduction of acute symptoms.

So I'm sorry to interrupt.

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BY MR. GOELMAN:

Q. No. Dr. Fishman, I don't want to rush you. Is there anything else in this particular CDG that you'd like to draw the Court's attention to?

A. (Witness examines document.) No.

Q. Okay. Let's turn to Trial Exhibit 5, which are the -- which is the 2015 version of the Level of Care Guidelines, and I want to direct you to page 81, 5-0081, which is entitled, I believe, "Residential CD."

A. Yes. (Witness examines document.)

Q. "Rehabilitation Residential for Substance-Related Disorders."

A. Yes.

Q. Do you have an opinion about whether this section complies with the generally accepted standards of care, Dr. Fishman?

A. I do. I think it is inconsistent with the generally accepted standards of care. And if you look at the preamble material and then at 1.3 and 1.4, I'm again concerned at the overemphasis and overnarrow focus on "why now" factors with acute signs and symptoms, acute changes, with the focus on those things with the omission of adequate consideration of cumulative severity for chronic and enduring problems.

Q. Okay. And can you turn to, let's see, Section 2.2, please.

A. Uh-huh.

Q. And is that another reference to custodial -- the custodial exclusion, the exclusion for custodial care?

A. Yes. So that material that we discussed before is echoed here in 2.2.3. Services that do not require continued administration by trained medical personnel would be excluded as being custodial.

Q. Okay. And turning back now to Section 1.3, do you see the reference there, again, to the "why now" factors?

A. I do.

Q. Okay. And do you have an opinion about the appropriateness of that under the generally accepted standard of care?

A. That's correct. I think both in 1.3 and 1.4 those are overemphasized.

Q. Okay. Overall, this treatment of requirements for residential treatment, do these comport with the generally accepted standards of care requirements for Levels 3.1 and 3.5 in the residential treatment band?

A. Well, so an example of the way that I had mentioned before that 3.1, and that is an example of a lower level of -- a lower level of residential care, one of the examples in 1.3 -- and, again, it's an example, but because of the repeated focus on imminent danger that comes up again and again, I think it's problematic with such a short list of examples -- the member is in immediate or imminent danger of relapse, and that would be a

permissive criteria for 3.7 but it would not be an appropriate criteria for 3.1.

So 3.1, if you remember, is a longer duration, less intensity, requires the availability of structure and monitoring but patients are typically out into the community. In fact, it is one of the purposes of 3.1 to engender community reintegration.

And we don't say that a person needs that level of care to prevent imminent relapse in hours or days but, rather, that there's a gradual consolidation of recovery skills and previous gains but that need to be reinforced over time with further recovery skills.

And to use as an example the immediate or imminent danger of relapse I think is narrow and overly restrictive. So another example of the way that the lower levels of residential care are not contemplated.

Q. Okay. Can you look at clauses 1.1, 2.1, 3.1, and 4.1 -- or 4.11? Do they all say "See common criteria for all levels of care"?

A. Yeah. Yeah, that's right. As I said before, those are included, each particular level of care specific guideline.

Q. So to be entitled to residential treatment under this part of the guideline, you have to meet both the specific requirements here and the ones that are common?

A. Yes. So that harkens back to the material about acute

changes that we discussed before.

Q. Okay. Can you turn to page 55, please, which is the intensive outpatient standard for substance use disorder.

A. I'm sorry. Direct me again.

Q. Page 55.

A. Okay.

Q. Intensive outpatient, is that what we saw before on your chart? It was shorthand IOP?

A. That's right. Level 2.1 or IOP, correct.

Q. And in your opinion does this guideline for intensive outpatient program for substance-related disorders meet the generally accepted standards of care?

A. No, in my opinion, it does not meet that.

Q. Why not?

A. Well, so there continues in the preamble here to be the emphasis on the "why now" factors, which I think is a consistent theme throughout these criteria, the emphasis on crisis-driven admission reasons and the reduction of acute symptoms as constituting the main focus of treatment.

Q. Let me ask you a question about that second paragraph in intensive outpatient program. It says (reading):

> "Course of treatment in intensive outpatient programs is focused on addressing the 'why now' factors that precipitate admission and to the point that the member's condition can be safely, efficiently, and effectively

treated in a less intensive level of care."

Is there anything wrong with that being the goal of treatment, to treat -- to move them into an intensive level of care?

A. A less intensive level of care.

Q. A less intensive level of care.

A. Yeah. I don't think that there is anything wrong with stepping people down as meets their needs, but I think that that is overemphasized here. So that, again, as I've said, "why now" is near exclusive the focus of the treatment; and the point at which we're ready to move on is when these acute symptoms are reduced and the user is urged to quickly get them to the less intensive level of care, which is one factor but there isn't the guidance that I would look for for outcomes in function, in recovery, in most effective treatment, and the like.

Q. What would the generally accepted standard of care be for somebody whose acute symptoms are under control but would benefit in terms of their chronic symptoms or comorbidities more from intensive outpatient than outpatient?

A. Well, it would be about the frequency of contact. It would be about the intensity of dose. It would be about the bundling of services in one place to overcome barriers to get to different kinds of services. It would be about the milieu in which there would be an atmosphere of a pro-recovery

environment both from the staff and from the other patients with peers propelling each other in a way that lower levels of care might not do.

And -- well, I'll stop there.

Q. And would such a patient under the generally accepted standards of care be directed toward IOP?

A. Yeah, that's right, and it might be because of ongoing chronic and enduring problems. For example, to use some of the examples I talked about before, the "why now" factors might have been something about a spouse or about an employer or about a medical problem, but there may be more indolent troubles with a chronic mental health issue; and although those weren't the things that got them to get into treatment, they are ongoing, they remain risky, they remain problematic, and the person might need ongoing intensity in this particular level of care even past the point of reduction of acute symptoms.

Q. Okay. Can you turn now, please, to page 70, which is the outpatient guideline for substance-related disorders. And, again, I'm going to ask if you have an opinion based on your experience whether this section complies with the generally accepted standards of care.

A. (Witness examines document.) I do not think it is consistent with generally accepted standards of care, and I have the trouble with, as we've discussed repeatedly, the

overemphasis and the narrow consideration of "why now" factors.

And in 1.4, I just want to -- I want you to think with me for a second about this notion of a chronic disorder with enduring vulnerability, like substance use disorder is. And 1.4 directs the user to think about recent changes from a baseline or from a previous level of lack of problems or a previous level of function, or changes in the psychosocial or environmental factors, but doesn't direct them to think about prevention of deterioration or maintenance of function or prevention of relapse or prevention of recurrent problems.

For patients with this chronic disorder, many of them need very long-term treatment even past the point of having problems, even when they're stable, with a focus on preventing relapse while they're in remission because we have no curative treatments. We don't know or can't easily predict when the remission doesn't need further booster care.

For some patients they need indefinite ongoing outpatient treatment, for some patients even lifelong, even in the absence of ongoing problems. And perhaps the analogy is to medical treatments for chronic medical conditions where there's enduring vulnerability but you still need to go get treatment for your chronic diabetes, your chronic hypertension even if it's under control for now exactly because the treatment is what's keeping it under control without acute changes.

Q. So this particular guideline authorizes treatment,

outpatient treatment, focused on addressing "why now" factors to the point where the "why now" factors no longer require treatment. Do you see that?

A. Yes.

Q. If the acute symptoms have made somebody with substance use disorder seek treatment, does that mean that that person is cured and no longer requires treatment of any kind, Doctor?

A. Well, I sure don't think so, but I think that there is the implication that if there were no longer symptoms or demonstrable functional impairment, that that would be the end or at least reflect attenuation of the rationale for further treatment.

And I think nothing could be further from the truth for many patients who are succeeding in ongoing, enduring, low-intensity treatment like outpatient treatment. It is the treatment itself and its enduring nature that is keeping them in good stead, and we would be remiss to discontinue it to wait for them to relapse to need further treatment.

Q. Dr. Fishman, we've just spent the better part of an hour looking at language in the Level of Care Guideline that was in force in 2015. For better or worse, we don't have time to go over all eight Level of Care Guidelines in detail, but I do want to direct you to the guidelines that were in force in 2011, which I think were the first version of the guidelines chronologically that you reviewed.

A. Can you direct me to those?

Q. Yeah. I'm going to ask you to start, again, with the common criteria. I'm sorry. It's Exhibit 1, Trial Exhibit 1.

A. Okay.

Q. And the common criteria start on what is internal page 4 but it's Trial Exhibit 1-0005.

A. Yep, I'm there.

Q. Okay. Similar to the 2015 common criteria, do these apply to all levels of care and to both mental health and substance use disorders?

A. That's right. They're subsumed by each of the level of care specific guidelines further on.

Q. Okay. And can you look through this section, please, and draw the Court's attention to any language that contributed to your opinion that the guidelines in 2011 violated generally accepted standards of care.

A. (Witness examines document.)

Q. I direct you to Section 6. And I don't want you to overlook anything, but you can focus on Section 6 and --

A. Yeah. So 6 resonates with the discussion we had before about what defines improvement, and here there is again a consideration of this time period. Again, not to put too fine a point on it, I wouldn't say that I would advocate for an unreasonable period of time, but it's the focus on a period of time that reminds us that the clock is running and the

atmosphere that is created, to my mind, is one of "let's get on with things." So that, for me, is problematic.

Q. What about Section 7?

A. And 7, although the term "why now," as was used in 2015 and also 2014, is not stated here, that language here is "presenting symptoms," and while not quite as pointed, I think it still contains the same concept, which is a focus on acuity, a focus on those things that are problematic now at this cross-sectional point of severity.

Certainly they're important to consider, but it excludes -- or omits, I should rather say, reference to things that are enduring. It's one point on the curve, not the entire area of cumulative severity under the curve throughout the patient's prior history.

Q. What is a presenting symptom, Dr. Fishman?

A. Well, a presenting symptom is what brings you in the door and is in many ways overlapping with the discussion we had about "why now." What is the crisis precipitant? What is it that causes you to seek treatment acutely?

Q. And is Section 8 another version of the exclusion for custodial treatment?

A. Well, 8 for me has a different kind of problem. It does intend, I think, to exclude things in distinction to things that are active treatment saying that things that are not active treatment would be excluded. The treatment should not

be primarily for these kinds of things.

The thing that is new here that I object to is to exclude treatment that might primarily be for addressing antisocial behavior or legal problems. So whereas I would agree if the intent were to say that just because a Court made a determination, that that might or might not be a logical conclusion of a treatment guideline.

I don't think it's reasonable to exclude antisocial behavior or legal problems as clinical manifestations and clinical features of substance use disorders. In fact, just the opposite. Antisocial behavior and legal problems are very common in substance use disorders. For many people, it is a core vulnerability that brings them either to using substances or performing behaviors to get substances or accelerating and increasing the harms associated with their substance use and needs to be addressed.

The addressing of antisocial behavior or legal problems is a central feature of what we do for some patients, not every patient, but for some patients with substance abuse disorder. To say that if treatment were to focus on that, it would be excluded because it's somehow apart from SUD treatment I think is not consistent with generally accepted standard of care.

Q. Do you recall that in the 2015 versions of the Level of Care Guidelines that we looked at before, the common criteria included criteria for admission, continued service, discharge?

A. I do recall that.

Q. That is not broken out in this iteration of the guidelines, but if you turn to page 77 or 78 of the exhibit numbering, so it's internal page 77, but it's TX0078, I think you'll find something with the heading "Continued Service Criteria."

A. That's right. So it serves the same purpose, but it's just organized in a somewhat different way at the end rather than in the common criteria themselves.

Q. Okay. Do you have an opinion as to whether the common -- sorry -- the continued service criteria in 2011 met the generally accepted standards of care for substance use disorder?

A. Well, I think that they are problematic and not consistent with the generally accepted standard of care. An example is number four. We talked about the issue of motivation or treatment participation. Here if a person is not actively participating in treatment or is not likely to fully adhere to treatment, they don't meet continued stay criteria and the service wouldn't be covered.

It's interesting to note that there is acknowledgment made that there might be an initial period of stabilization in which that wouldn't happen, and there might be a period in which additional motivational support might be needed. But I'm concerned that that directs the user to some kind of brevity of

what that intervention would be past which, whatever the time is -- and it's not specified, which is okay -- but that past that time that we're done with this and we're done with stabilizing and we're done with motivational support, and either you've got it or you don't and then you would not meet continued stay criteria.

And what I think is more consistent with generally accepted standards of care is that we keep at it and that motivational enhancement and trying to persuade a person to do incrementally better at adherence over time is much more likely to be the path that people follow. Three steps forward, two steps back. To expect something different, some kind of unilinear direct pathway to recovery without some opposition, without some problems and participation, without problems and adherence, I think is unrealistic.

Q. And this list of 11 criteria, it says at the top that all of the following criteria must be met for continued service; is that right?

A. That's correct. Right.

Q. So failure to meet any one of them would disqualify a patient from care?

A. No, that's right.

Q. Can you turn to Number 8, please.

A. Yeah. So 8 is one that asks for the tracking of progress, which in and of itself I think is reasonable, but I think that

the level at which that is expected, this idea of clear or compelling evidence -- clear and compelling evidence, that's a very high standard. It's not really a medical term, and it would be hard to know what that would exactly mean in a clinical treatment except that it sounds to the user or it would direct the user to think that we're watching closely and if it doesn't meet that high threshold, that that's not adequate and that isn't measurable progress and that the treatment would be excluded.

Q. So there you either have to have already achieved measurable realistic progress or show by clear and compelling evidence that continued treatment of this level of care is required to prevent acute deterioration or exacerbation?

A. Yes. And it seems to me that that is an overly high threshold that results in over-restrictiveness.

Q. Can you turn now to page 55 internally, or TX1-0056, for the residential treatment for substance use disorder?

A. Yeah. I'm there.

Q. Okay. And earlier you had identified in 2015 Level of Care Guidelines the section that said that fail first was not required. Do you see that -- I mean, do you recall that?

A. That's right. We discussed that in 2015.

Q. Okay.

A. It was explicitly contradicted, yeah.

Q. Is there a fail first requirement in this 2011 version?

A. Yes. Number 1 right off the bat is a strong fail first criteria. So the member continues to use substances despite appropriate motivation and recent treatment. That's problematic to me in both ways, both because a person has to have had and been in and participated in treatment in an IOP, and also they have to have been motivated towards that participation.

I think that here this is the inclusion of a fail first criteria, which although later rejected, here is clearly in contradiction with the generally accepted standard of care.

Q. And was -- the fail first requirement, was that something that was consistent with generally accepted standards of care back in 2011?

A. Very much so.

Q. Fail first was consistent?

A. No, no. Very much not consistent.

Q. Okay.

A. I apologize.

Q. I misheard you.

A. Yeah.

Q. What about the fifth criteria here in the list?

A. Well, before we get to 5, I have concerns with 2, 3, and 4, which although it's appropriate to look at deterioration of function in 2, it's appropriate to look at exacerbation of a co-occurring medical condition in Number 3, and it's

appropriate to look at developing withdrawal symptoms in Number 4, in all three of those, in 2, 3, and 4, the metric is that the person cannot be safely treated in a less restrictive level of care.

And although we certainly want to be mindful of not leaving a person to an unsafe situation, that's not sufficient. We also want them to not be in a level of care where they cannot effectively be treated.

So for deterioration of function, for exacerbation of a co-occurring medical condition, and for the development of withdrawal symptoms, we also want that -- the level of care be considered as not effective, and that should provide a pathway to the higher level of care.

It's also interesting that although co-occurring medical conditions are mentioned, there's the kind of glaring and conspicuous absence of co-occurring mental health conditions not mentioned as a pathway.

Q. And that is a dimension reflected in ASAM Assessment Dimension Number 3?

A. ASAM Dimension 3.

Q. Okay. Do you see at the top of this list it says "Any one of the following criteria must be met"?

A. I do.

Q. Why, then, do you find this list of inclusive criteria objectionable, Dr. Fishman?

A. So you're right to point out that any one not being met doesn't exclude that another one might be met, but it sure narrows the portal that more than one of these criterion are flawed, and then in aggregate you have only a very narrow portal or create only a very few number of nonflawed pathways to get in. So if a person can't reasonably meet this one or this one or this one, then we're left with not enough.

Remember what we talked about is that we want to look for the diversity, the heterogeneity, and the multiplicity of different pathways as meeting the needs of different kinds of individuals and there's, I think, restriction by not having enough appropriate and unflawed pathways in in the ways I've described.

Q. Put it this way: Are there patients with substance use disorder who, under the generally accepted standards of care, would be eligible for residential treatment that would not meet any of these six criteria?

A. Well, yeah. I think we could come up with a hypothetical patient who, in my view, by the generally accepted standards of care or as -- sorry, going too fast -- by the generally accepted standards of care and as also articulated in the ASAM criteria would appropriately be placed in residential treatment but might not find a pathway in by one of these six.

So, for example, a person whose co-occurring psychiatric disorder, mental health problem, say it's depression or

psychosis, is chronic and puts the person at risk of further functional deterioration and might have not relapsed to substances but based on past history of the course of illness might be at high risk, say they've stopped taking their antidepressant, they've stopped taking their antipsychotic, and we have the historical kind of pattern in previous times, that that, I wouldn't go so far as to say inevitably, but likely based on past behavior predicting future behavior -- based on past behavior leading to future behavior predicts with some probability that the person would be at risk and would need the combined bundled intensity of this level of care, but that wouldn't be indicated here as a particular meeting any one of these.

Q. Dr. Fishman, turning to the next section, which requires that all of the criteria be met in order for the patient to be eligible for residential care, can you point out language there that supports your opinion that this level of care guideline violates the generally accepted standard of care?

A. I apologize for interrupting. I just want to go back because I think I didn't mention a problem with number 5, in the first section. Any one of the following criteria might be met.

I very much like that there's a consideration of the Dimension 6, home environment, recovery environment, living situation. But, once again, I think the way that this is

articulated in number 5, severe impairment in the member's family or social support system has heightened the risk, et cetera, is overly narrow because I think there are other ways in which a Dimension 6 recovery environment, home environment, can be problematic.

It might not be that the home environment is severely impaired. But it might be that enduring vulnerabilities of the person through their own qualities don't allow them to digest the support, or that they bring to the table a conflict with the home situation that isn't because the home situation is itself impaired, but because that person's own vulnerabilities bring it to the table as a problem.

So it's that -- it's too narrow in the requirement, again, for me.

Q. Okay. And then, again, turning to the next section, all of which contain criteria, all of which have to be met.

A. Yes.

Q. Are there any of these criteria that you believe contribute to the violation of generally accepted standards of care by the 2011 version of the Level of Care Guideline?

A. In particular number 2.a highlights, again, another way in which in the UBH criteria don't encompass and consider the full range of the residential levels of care.

So the comprehensive evaluation by a psychologist or an addictionologist while absolutely appropriate for the highest

medically monitored 3.7 level of care, would not be necessarily or typically appropriate or required for the lower levels of residential care such as 3.5, 3.1, where the involvement of medical personnel would not be central to the treatment.

In fact, there would be a comprehensive evaluation, presumably by a different kind of clinician. And so requiring a therapist, a psychologist, a counselor, but a nonmedical personnel clinician. And so to require that it be medical again focuses our emphasis only on the highest levels of residential care.

Q. And can you turn to criteria 5, please.

A. Yes.

Q. Does that also reflect a standard required for 3.7 and not for lower levels of residential treatment?

A. That's right.

We certainly want the near continuous, if you will, revision of the treatment collaboration between the treatment team or a provider and the patient. But it might not be at a lower level of residential care. In fact, it wouldn't be at a lower level of care a medical personnel.

The other thing, to set the clock on every five days depending on which of the residential levels of care might be overly burdensome and overly restrictive.

It would be one thing if we were talking about a level 3.7 medically monitored treatment where the treatment is measured

in one to three weeks and then every five days we could argue, you know, is a reasonable criteria for a formal re-review.

But if we were talking about 3.1, where the treatment duration might be measured in months, even 6 to 12 months, then the formal requirement for a re-review every five days would seem to me quite burdensome and have the effect of placing a barrier to access to continued stay and treatment.

Q. This section says you don't have to have a five-day re-review if you provide, quote, compelling evidence that continued treatment in the current level of care is required to prevent acute deterioration or exacerbation of the member's current condition? Do you see that?

A. I do.

Q. Is that standard, compelling evidence, is that something that has a meaning in the substance use disorder field?

A. It isn't really something that's operationalized in the medical lexicon. I don't know what it means. Surely, if you're going to show something you want to say you have some evidence for it.

But to say it's compelling evidence is once again to, I think, create a high bar and create the notion that you're under the microscope for if it's not good enough then it won't do. And I think that that is restrictive.

Q. Dr. Fishman, I have two more sections from the 2011 Level of Care Guidelines I would like to show you.

MR. GOELMAN: I think we can do this fairly quickly.

THE COURT: Go ahead.

BY MR. GOELMAN:

Q. Let's turn to page 41 or TX 10042.

A. All right.

Q. And this is for intensive outpatient IOP?

A. Yes.

Q. Same drill as before. Can you point us to any of the language in here that informed your opinion that this particular guideline is not consistent with generally accepted standards of care?

A. Sure.

Number one is a requirement for motivation. So if a person continues to use substances but they are not motivated to continue to use substances or motivated to participate in treatment, then this criteria wouldn't be met.

And, as we've discussed before, I don't think it's reasonable to require motivation for admission. Creating or enhancing motivation or doing persuasion work is part of what we do in treatment, and we expect people, or some people, some subset of patients to be poorly motivated.

Number two, the treatment cannot be safely managed in the less intensive level of care.

Again, the undue and narrow focus on the imminent danger consideration. And, certainly, we want to avoid danger, but we

also want to be concerned with the effectiveness of treatment or the lack of potential effectiveness at a lower level of care, less intensive level of care, that would then bump us up and require a careful consideration of higher level of care.

Number 3, it puts undue focus. Here it says, "The member's mood, affect or cognition has deteriorated to the extent that a higher level of care will likely be needed if treatment in IOP is not provided."

So that focuses us that the goal of treatment is to provide skipping up a level to the next higher level of care. And that might not be the goal of treatment. The goal of treatment might be that this level of care is required to get more effective treatment outcomes.

Q. Okay. Turning to the list, the "All of the following list" that begins at the bottom of that page.

A. Yes.

Q. And turning to criterion 5, is that another reference to the need for motivation and a supportive family environment?

A. That's right.

So I'm all in favor of trying to bring to bear support in the family or other aspects of the recovery environment. But to make it a requirement that a family or other aspects of the social support system can understand and comply is not reasonable.

There might not be such social supports. It might be, in

fact, the family is opposed or in opposition to treatment and can't or won't cooperate. That shouldn't exclude the member from getting the needed treatment.

An the alternative is here stated that the member is likely to participate. Again, we discussed this. At the outset, they may not be likely to adhere to the level that we want, and that may take time. And that may be the focus of motivational enhancement treatments rather than expecting them at the door to participate in treatment.

Q. And what about criteria 6 and 7, and the requirement that psychiatrists complete the confidential evaluation and then continue to see the member?

A. So that shouldn't be, according to generally accepted standards of care, a broad requirement for all IOP treatment. Certainly, some IOPs may be what we call co-occurring enhance, specialty dual diagnosis programs that say our focus is going to be on Dimension 3 problems, mental health, psychiatric problems, they will certainly be expected to have a psychiatric involvement.

But many IOP programs with treating patients without particular problem focus in the mental health or psychiatric arena would not be expected to be medically monitored or treatments medically delivered.

And the requirement to have a psychiatrist, or else patients aren't given treatment, is another way in which these

are overly restrictive and provide barriers to access to this needed level of care.

Q. Can you look at criterion 8, please.

Is that another iteration of the requirement that a treatment plan be updated every 3 to 5 days or compelling evidence that continued treatment is required to prevent acute deterioration or exacerbation?

A. I agree it's another iteration of a concept we talked about that we are moving an accelerated clock that's not appropriate for this level of care.

We often think of the modal treatment duration for intensive outpatient treatment being, you know, crude average, from 4 to 12 weeks for patients who are successful. It's often longer within that range.

And so to have to provide a formal treatment plan update every three to five days, I think, is overly burdensome. If the alternative is, again, this compelling evidence, again, I think that that's too high a standard and difficult to meet providing a barrier.

Q. Last section in the 2011 Level of Care Guidelines, page 45 of the guidelines, or Trial Exhibit 1-46 Outpatient for Substance Use Disorder.

A. I see it.

Q. What is your opinion as to whether or not this particular guideline comports with generally accepted standards of care?

A. Well, the thing that is so concerning to me is number 2, right off the bat, that a lapse has occurred or is imminent.

Q. Why is that concerning?

A. So, as we discussed, in 2015, where it was phrased in "why now" or changes, here it's phrased explicitly in the need for a -- having occurred lapse or imminent lapse.

Again, the focus on problems and destabilization. And if those things occurred, for sure they are harkening to the need for treatment. But one of the purposes for low intensity treatment at this level of care, outpatient treatment, is to continue maintenance of stability and to continue maintenance of remission if a person is in remission. And to require that they relapse or lapse in order to meet criteria for treatment is to, I think, pervert a core function of outpatient treatment, which might be indefinite, even lifelong checkups and maintenance of function and booster sessions and the like.

Q. Okay. There are three different lists of criteria for outpatient. The first one says, "Any one of the following criteria must be met"?

A. Yes.

Q. Second says, "And all of the following"?

A. Yep.

Q. And then the third says, "Consider whether outpatient treatments needs to continue in any one of the following criteria is met."

A. Yes.

Q. Do you see that?

A. Yes, I see that.

Q. Just globally looking at these criteria, Dr. Fishman, is it your professional opinion that this level of care guideline violates the generally accepted standards of care that were active or accepted in 2011?

A. Yes, that is my opinion.

MR. GOELMAN: Okay. Your Honor, I believe this would be a good time for a break.

THE COURT: Okay. Then we'll break.

I will see you at 1:30.

(Recess taken at 12:34 p.m.)

Tuesday, October 16, 2017 1:40 p.m.

P-R-O-C-E-E-D-I-N-G-S

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THE COURT: Okay. Go ahead.

MR. GOELMAN: Thank you.

BY MR. GOELMAN:

Q. Dr. Fishman, we've now looked at some of the provisions in the 2011 and 2015 UBH Level of Care Guidelines.

Earlier you testified that it was your opinion that the Level of Care Guidelines in use by UBH between 2011 and 2017 all violated generally accepted standards of care.

Do you recall that?

A. I do.

Q. And is that for substantively the same reasons that you've just pointed out with respect to the 2011 and 2015 versions of the guidelines?

A. That's right. I think that there is an aggregate and consistent difficulty with each of the years, some to a greater or lesser extent than the individual provisions. But in their totality, those are the reasons that pertain, and I agree for all of those years.

Q. Dr. Fishman, earlier you testified that one way that the UBH guidelines violated the generally accepted standards is that they did not contain specialized criteria applicable to kids, youth, and children?

A. Yeah, that's right.

Q. Are there, according to ASAM, more permissive standards for youths/kids to get treatment than would apply to the same -- if the patient was an adult?

A. Yes, that is true.

For any given level of care, the entry criteria, that is, the decision rules for matching treatment severity and needs to level of care, are more inclusive, more permissive for adolescents.

So that might be because the criteria themselves are specific to a lower level of severity. An example may be, in Dimension 1, not requiring as high a level of severity, not

having evidence for outpatient levels of medical detox. That's just one example.

Another way is that the way that decision was for each individual dimension combined are more permissive, requiring two of the dimensions to apply to a particular level of care, perhaps, instead of three or more compared to adults.

So in a variety of ways, we tend to think that youth would need higher levels of care for longer durations with lower barriers to access than adults.

Q. Dr. Fishman, in addition to soliciting your opinion as to whether or not the UBH guidelines were consistent with the generally accepted standards of care, did plaintiffs also ask you to consider the UBH guidelines against the Texas Department of Insurance regulations applicable to substance use disorder?

A. Yes, that's correct.

Q. And did plaintiffs also ask you to review certain expert reports disclosed by UBH and write a rebuttal report?

A. Yes.

Q. Let's turn to Texas first. Can you look at Trial Exhibit 661, please.

A. That is not in this book. Is that a separate book?

Q. Yeah, a book behind you.

A. And you say 661. Okay. 661.

Q. Are those the State of Texas regulations that you reviewed as part of your work in this case?

A. Yes, they are.

MR. GOELMAN: We offer Trial Exhibit 661, Your Honor.

MR. RUTHERFORD: No objection, Your Honor.

THE COURT: They are admitted.

(Trial Exhibit 661 received in evidence.)

BY MR. GOELMAN:

Q. And are these the Texas Department of Insurance regulations for chemical dependency treatment centers?

A. Yes.

Q. And for IOP -- I'm sorry, intensive outpatient and outpatient?

A. Yes.

Q. Okay.

A. And residential, yes.

Q. And residential.

Does Texas call residential "chemical dependency treatment centers"?

A. Uh-huh.

Q. What did you do to analyze whether or not the Level of Care Guidelines that UBH was using were consistent with the Texas regulations?

A. Well, I read through these Texas guidelines, and then I was able to compare them, both to the UBH guidelines and then to my background, knowledge, and experience of the generally accepted standard of care, including the way they are

articulated by the ASAM criteria.

Q. Okay. Focusing for the moment on the applicability or the differences between the UBH Level of Care Guidelines and the Texas regulations, did you come to any opinion after your review?

A. Yes, I did. And it was and is my opinion that the UBH criteria are not consistent with these Texas guidelines.

Q. And was that for essentially the same reasons that you found the guidelines to be inconsistent with the generally accepted standards of care?

A. That's right, broadly because the UBH criteria are more restrictive than these Texas guidelines, do not provide sufficient diversity of pathways to meet specific patient needs, and provide restrictions and barriers to access to care for all of the reasons that we've already talked about.

Q. Dr. Fishman, are you familiar with the term "average length of stay"?

A. I am.

Q. What does that mean?

A. So average length of stay, or average length of service, is the amount of time that a person spends in a particular treatment context. So it might be the number of nights or days that a person spends in a residential treatment program or the number of sessions a person attends an IOP or an outpatient treatment.

Q. Can you turn to page 14 of the Texas regs, or Trial Exhibit 661-015?

A. Uh-huh.

Q. Is this recommended length of stay for inpatient rehabilitation treatment?

A. I see that.

Q. Okay. And what does the Texas Department of Insurance recommend in terms of length of stay for residential treatment?

A. So, in their guidelines, they make the recommendation, and. It's a range, but they've said that the recommended length of stay for adult admissions to what they call rehabilitation, slash, residential treatment is between 14 and 35 days, and for adolescents between 14 and 60 days.

Q. And those are the recommended length of stay for both residential treatment and for inpatient, the Level 4 level of care?

A. That's correct.

Q. And you testified earlier that, generally, the higher the level of care, the shorter the average length of stay was; is that right?

A. That's correct.

Q. Can you turn now to page 20 of the regs, or 661-21.

A. Yes.

Q. Okay. And is that similar -- does that contain similar recommendations for intensive outpatient as opposed to

residential?

A. It does. And it gives a recommended intensive outpatient, or an ASAM, the numbering is Level 2.1. Recommended length of service or length of stay are from 4 to 12 weeks as a range.

Q. Okay. And are there different numbers there for youth versus adults?

A. No. In this case, they don't give that.

Q. Okay. Are you familiar with treatment episode data, or TEDS.

A. I am.

Q. And what is that data?

A. So the TEDS data set, the Treatment Episode Data Set, is a national data set compiled by a federal agency, SAMHSA, Substance Abuse and Mental Health Services Administration. It's collected from throughout the country as a report of, I don't know, 1 to 2 million episodes of care annually.

And they report it each year with a whole host of statistics. That reporting, as I understand it, is mandated in states for many providers. And it gives a snapshot, if you will, of national treatment.

And they might have reasons for admission. They might have drugs of choice. They might have average length of stay. So there's an annual published report about that data set.

Q. Okay. Do you have Trial Exhibits 699, 700, and 701? There may be another binder.

A. Okay. Another binder. 699.

Q. And --

A. And this is the 2011 TEDS report.

Q. Okay. And is 700 the 2012?

A. 700 is the 2012.

Q. And 701, the 2013?

A. Yes, the 2013.

MR. GOELMAN: Your Honor, plaintiffs offer Trial Exhibits 699, 700, and 701.

MR. RUTHERFORD: Your Honor, we would object on the basis of the fact that this wasn't a basis of his opinion or his rebuttal opinion. Neither one of these documents -- none of these three documents were relied upon.

MR. GOELMAN: He is not now offering an opinion, Your Honor. You indicated that, if we wanted to admit documents we had to have a sponsoring witness. I think Dr. Fishman is probably as good as we're going to get for this kind of data.

THE COURT: That's not what I meant by sponsoring witness.

You don't get to put something up there and just have it admitted into evidence and not have somebody talk about it. You have to have somebody actually explain the significance of it.

What are you going to use this document for?

MR. GOELMAN: To show what the TEDS data says about

average length of stay for --

THE COURT: Who are you going to do that through?

MR. GOELMAN: It's in the face of the data, Your Honor. It's in the report.

THE COURT: Fine. Sustained.

As I said, I am not going to sit there in chambers and go through 10,000 pages of documents that you haven't gone through specifically with a witness on the stand right here and explain exactly the significance, nor can you do it with an expert that you haven't qualified to do that.

So figure out some other way, but that's not what's going to happen. So it's sustained.

BY MR. GOELMAN:

Q. Dr. Fishman, you've practiced in the field of substance abuse disorder for 25 years?

A. Yes.

Q. And during that time have you become familiar about the average ranges of time that people spend in different types of treatment?

A. Yes, I have.

Q. Does that include different levels of residential treatment?

A. Yeah. It includes residential treatment and it includes outpatient treatment.

Q. Okay. And how have you become familiar with those kinds

of averages, Dr. Fishman?

A. I've become familiar as an attending physician directly supervising clinical care, and I've become familiar as a medical director doing administration, overseeing the work of other practitioners and the organization as a whole, and have seen utilization of data and seen individual episodes of care.

So I have a feel, and I've also talked to many other practitioners who shared with me their experience and their particular circumstances.

Q. And based on your professional experience, Dr. Fishman, can you say what the average length of stay or a range of average length of stay is for different levels of residential treatment?

A. Yeah. I think it's important to stress that it is a range. Certainly, individual circumstances and individual patient severity and treatment needs, as we've been discussing throughout the day, those would pertain. But you get a sense of the range. Certainly, there are outliers, but you get a sense of the range.

And so it's worth looking at from all the different levels of care. In a hospital setting, a level 4 setting, it's usually a few days to a couple of weeks except for the most severe patients.

In a level 3.7, or a medically-monitored residential treatment, it's in the range of one to four weeks. I think in

my programs the average is somewhere around three weeks. But, again, it's a range.

In level 3.5, or medically-managed residential treatment, that range might be 4 weeks to 12 weeks.

In level 3.1, or low-intensity clinically-managed residential care, it's typically measured in months and might, be 6 to 12 months for some patients.

In intensive outpatient care, or Level 2.1, per the ASAM designation, it might be in the range of 4 to 12 weeks, sometimes 16 weeks. But 8 to 12 weeks is often what we're shooting for, again, with variation based on individuals.

And, as I've said before, for level 1 outpatient care, it's such a wide range because for some patients it might be indefinite, and even the goal being lifetime if we can retain them that long, if the patients are lucky enough to sustain that engagement for that long.

Q. Thank you, Dr. Fishman.

Is your rebuttal report, which I think is marked for identification Exhibit 882, in that binder.

A. I will look.

Fishman report, yes.

Q. Were you asked by plaintiffs to review reports proffered by UBH by Dr. Simpatico, Dr. Goddard, and Dr. Alam?

A. I wrote a rebuttal report having read the reports of Dr. Simpatico and Dr. Goddard. I believe the report of

Dr. Alam crossed paths at the time that I was writing this report.

Q. So you did not include in your rebuttal report your rebuttal to Dr. Alam; is that right?

A. That is correct.

Q. Did you later set forth your opinion with respect to Dr. Alam's report at your deposition in this case?

A. Yes, I've discussed that.

Q. Turning to Dr. Simpatico first, without going over ground that we've already tilled, can you tell us what your opinion of -- what your reaction was upon reviewing Dr. Simpatico's report?

A. Well, I disagree with Dr. Simpatico. He contends that the UBH criteria are consistent with the generally accepted standards of care. And I disagree.

He tried to make arguments as to why his position was correct. I'm not persuaded by them. But I will just talk about some highlights.

One of the things that he emphasized is that, in his view, there are some key principles of the generally accepted standards of care which, in his view, the UBH guidelines do uphold.

One that he wanted to emphasize in his report was what he calls least restrictive effective setting. Meaning that it would be consistent with the generally accepted standards of

care to have patients treated in levels of care that are least restrictive and effective.

That's a generally standard approach, and I agree that it's an important principle. But his emphasis is really very narrowly on that component of "least restrictive and effective"; that is, least restrictive with very little focus on what I consider to be as important, or maybe more important, but certainly equally important, the component of being effective.

And he argues that least restrictive is so important because it upholds patients' freedoms and liberties and harkens back to the evolution of that standard; that is, in the excesses in decades past of involuntary confinement in longer-term inpatient psychiatric hospitals, before we had a standard of what it was to require a due process for patients to be protected, protected against involuntary commitment against their will, to be protected against not being provided active treatment.

And I thought that that really wasn't germane to the argument here since none of the residential care that we're talking about is involuntary. The protection of people's civil liberties in settings in which they are confined against their will is not relevant.

These are patients who are voluntarily seeking treatment. And the question is whether or not that treatment that they

seek, and that their treatment providers agree should be sought, is covered, not whether they are being adequately protected from harms.

And we have clear regulation for procedures for due process. And they would be protected in any case not so much through the criteria but through those procedures and that regulation.

So I thought that that was not persuasive to me. And, again, "effective" is the more important but certainly equally important to "least restrictive."

Another thing Dr. Simpatico took issue with, with my report, was his objection that he thought I maintained that the ASAM criteria was the only picture of the generally accepted standard of care. And he argued that there was no single one articulation of the generally accepted standard of care.

And I agree with him that ASAM isn't the only and the only possible. For me, it's just the best one and the one that best articulates it and reflects it. But I'm not committed or wedded to the idea, as he claims, that there could be no other and that the ASAM numbering and the ASAM words and the ASAM organization is the only one. As I've said before, as long as the concepts are there and that they have decision rules that comport with the generally accepted standard of care as we've been discussing.

Another thing Dr. Simpatico agreed with me about is this

issue we've talked about, about the distinction between active treatment and custodial care in which I claim, and still claim, that the UBH criteria overly depict a narrow concept of active care and an overly broad definition of the concept of custodial care.

And he again went to the language, which I discussed earlier, that there was an overemphasis on reduction or control of acute signs and symptoms and the improvement to some higher level and restoration of some higher level of function not sufficiently emphasizing restoration -- I mean, not sufficiently emphasizing prevention of deterioration and maintenance of function.

And so, again, that's an area in which I disagree. And I think that he and the criteria themselves quote the CMS language out of context without really going to the full explanation, and overemphasizing acuity.

Q. And, Dr. Fishman, in terms of your and Dr. Simpatico's disagreement about acuity or the "why now" factors, do you ever express the opinion in your report or in your testimony that acute or "why now" symptoms should be ignored?

A. No, not at all. I do think that acute symptoms should be and must be considered. And I do think that even the way that that is phrased, as "why now," those things ought to be considered.

It's a useful clinical tool. One of its main purposes is

to try to get a sense of what motivates a patient. I certainly want to know why a patient came to treatment today but not last week, but not next week.

And the reason that's so important -- not because that's the only thing to consider, not because that's the only and exclusive focus of the treatment plan, but because it's important for me to understand what motivates a patient.

And so remember what I said before when we were going through the dimensions, and I said I often like to start with Dimension 4. This issue of treatment alliance and therapeutic engagement is so important. You want to know, well, what motivates the patient. I may have my reasons why I think it's so important, but they may not be the same as the patient's. So understanding what drew them in, what brought them in the door, helps me appreciate what to focus on in meeting them where they are at.

And it is a condition, as we talked about, that waxes and wanes. And motivation flags. And I know later on I'm going to have to come back to that well and dip in it again. So that's why I want to identify "why now," so I can come back and say remember what got you here, let's focus on that when they flag and they say, maybe I'm not as interested anymore.

So it's a vital clinical concern, but it is not the sufficient exclusive focus of treatment to only focus narrowly on "why now." But I do think it's important.

Q. Okay. Turning to Dr. Goddard's report, did one of the opinions expressed in Dr. Goddard's report have to do with the existence or nonexistence of a single nationally accepted description of the generally accepted standards of care?

A. Yeah. Dr. Goddard also makes the point that there is no single nationally accepted set of criteria. And he claims that I did make that assertion. But I disagree with him. I think that there are generally accepted standards of care.

Those are part of the consensus of expert practitioners in the field, and I believe that they are well articulated and expressed and reflected in the ASAM criteria. But I don't think that the ASAM criteria are the only possible version, the Holy Bible necessarily. I just think they're well described and do a good job.

Q. So to the extent that Dr. Goddard opines that there are no generally accepted standards of care in this field, you would disagree with that?

A. I certainly disagree. I think there clearly are generally accepted standards of care that shape practice, as it should be.

Q. Turning now, finally, to Dr. Alam's report, I think that is Exhibit 808, expert report of Dr. Alam?

A. Yes, I have that.

Q. One of Dr. Alam's opinions is that the UBH levels of care guidelines do comply with the generally accepted standard of

care. You've already stated that you disagree with that, and that your opinion is that the guidelines do not comply with GAS. And you explained the basis for your opinion at some length. So I don't want to go over that ground again.

But is there anything in addition to all the problems that you've already identified in the levels of care guidelines that you disagree with Dr. Alam on?

And I would refer you to page 12, footnote 36, where he's discussing the continuum of care for residential treatment.

A. Sure. Well, there's a couple of points. He again makes the same point that -- asserting that I think that the ASAM levels of care -- the ASAM level of care guidelines is the only single nationally accepted standard. I've explained why I don't think that's the case. So we continue to disagree.

He thinks that ASAM is not as broadly as disseminated and well-known as I think. I disagree with him about that. I think anybody with experience in this field, any addiction physician, any addiction practitioner would be able to recognize the ASAM criteria and be able to describe its purposes.

But, in particular, the point that you refer to is on the matter of my contention that the UBH criteria do not appropriately consider the full range of residential care. So not just 3.7 but 3.5, 3.3, and 3.1, the lower levels of residential care.

He dismisses that in part by saying, well, those levels of care don't really exist much anyway, and they're not found very frequently, and they couldn't be part of the standard of care if they're so rare, and so let's not focus on them and make such a fuss.

I disagree entirely with him about that. I think that they are very common. I think they are found in many communities. I couldn't claim it's every community. But just to give you an example, one of the natural English descriptors of what in ASAM is called 3.1, low intensity, clinically managed residential treatment, is a halfway house.

Halfway houses are very common throughout the country as a level of care that is widely used. So I don't agree with him that they are not commonly found. I think they are commonly found. I think they ought to be commonly found. I think they ought to be covered.

And I think that it is part of the generally accepted standard of care that a criteria that purports to do what it's supposed to do to put patients in the right place ought to give us instruction sets for how to do that, including those levels of care.

Q. Okay. Turning now to page 11, paragraph 46, of Dr. Alam's report.

A. Page 11?

Q. Yeah, page 11. That involves a purported discussion or

series of discussions that, according to the report, you and Jerry Shulman were involved in as part of a group of Parity Implementation Coalition.

Do you know what the Parity Implementation Coalition is or was?

A. So I don't have as good a recollection of all these details. I do recall that I was introduced to an endeavor along those lines around the time that we're talking about, by Carol McDade, who's a nationally known treatment advocate and specialist in parity.

As I recall, there was a conversation that she was trying to broker between some frustrated treatment providers who contended that certain managed care company or companies -- I can't remember which one or ones -- were not adequately providing coverage for care that they thought ought to be covered.

They wanted to broker -- or Carol McDade wanted to broker a dialogue in the conversation to try to educate reciprocally. She brought ASAM members into the conversation to see if a dialogue could be had, a series of conference calls.

I don't recall that Dr. Alam was involved. He says he is. I don't doubt that that's so. I don't recall that Jerry Shulman was involved. I recall that it was Paul Early, who's another prominent ASAM member and a member of the steering coalition, steering committing for ASAM. But, in any case,

yes, I do remember it happened.

We divided and conquered a little bit. My particular role was to bring to the group, if I remember correctly, some of the background of the research that supported the ASAM criteria and describe what the empirical kind of background was.

And it was Dr. Early's role to look at some of these cases that were thrown out as examples and to review whether or not they met the ASAM criteria matching. I can't recall the details. He did most of the talking on those conference calls.

I remember that I agreed with what he was saying. And we agreed with some of the things and disagreed with others of the things, but I can't recall more detail than that.

Q. Okay. So just so I understand your testimony, you don't recall Dr. Alam being part of those discussions, but he may have been?

A. He may have been, sure.

Q. Okay. Did you ever, as part of the Parity Implementation Coalition, or in any other form or context, express support for the UBH Level of Care Guidelines or voice the opinion that they complied with the generally accepted standard of care?

A. No, not at all. It wasn't part of the exercise at that time to review the UBH guidelines, so I didn't do that.

But when we looked at the decisions made for these particular cases and compared them to the ASAM criteria, they were in some instances contradictory with whatever decisions

had been made.

But I would never -- knowing what I know now about the UBH criteria, now that I've reviewed them, I would never have endorsed the UBH criteria as meeting the generally accepted standards of care. I don't think they do.

MR. GOELMAN: No further questions.

MR. RUTHERFORD: Your Honor, if I may, if there are references to prior deposition testimony, does the Court want a mini or a larger version?

THE COURT: I don't want any of them unless I have to have them.

MR. RUTHERFORD: Understood.

THE COURT: Well, so maybe I ought to ask this question now, rather than after cross-examination.

Dr. Fishman went through some portions of the Level of Care Guidelines. Who's going do the rest of all those Level of Care Guidelines? Or did you expect me to extrapolate somehow even though the language is slightly different?

MS. REYNOLDS: Your Honor, there is another expert witness who will go through additional years. Some of the years have identical criteria. And if they are identical, we don't intend to go into them in depth.

THE COURT: Well, or at all?

MS. REYNOLDS: Hum?

THE COURT: Or at all?

MS. REYNOLDS: I mean I expect that the experts will give their opinion on the criteria --

THE COURT: Well, so here's my problem.

MS. REYNOLDS: -- without repeating them --

THE COURT: Maybe I ought to make myself clear.

At the end of the day, with respect to every level of care guideline, and presumably by inference most of the other guidelines, I'm going to go through line by line only as to those sections of Level of Care Guidelines that you have specifically challenged, okay.

And with respect to those, I'm only going to -- I'm not going to figure out for myself what's wrong with them; right? I mean, I certainly have my own opinions reading them, but I'm just some dumb judge. I'm going to rely on the experts on both sides or people from UBH who are experts in their own way.

I'm not going to try to figure it out. So if you want me to draw an inference -- and I expect that is the bulk of the plaintiffs' case, is each section, each particular two sentences of a guideline is wrong for the following reasons, okay.

So you have to make sure that you have somebody testifying that that exact way it's worded in this context is wrong for the following reasons. If you don't, I'm not going to try to figure it out for myself.

So I'm not going to apply the general sense of they

overemphasize acute care to a different kind of language about urgency in some other guideline.

So I expect by the end of this for you to have given me chapter and verse on every single one, because what I'm going to, in return, do is go through the guidelines and say, this one is fine here, it's not fine here, it's not fine here, it's fine here, it's not fine here. That's what I'm going to do. So none of that can be done unless you have specifically challenged a particular.

Now, if it's the identical verbiage, that's fine, but you've got to make it clear it's the identical verbiage. And if I were you, I would put the identical verbiage up in front of an expert and say, Here it is. That's the same thing; right?

Doesn't do me any good to say, oh, they're all inconsistent with the guidelines. It's almost -- almost useless. Or they're all inconsistent in the same way. It's almost useless.

It's got to be this section and this section and this section.

So I'm happy to proceed with cross-examination, but you may need to do some more work, because that's -- at the end of this, I should have a roadmap from the testimony as to what you think is wrong with every section of every guideline that you think is wrong.

And, similarly, the defendants are going to have to challenge every single one of those. Otherwise, I won't have the rebuttal to it.

So that's the roadmap I want. And I can't -- this can't be done on a general level. And so we started off in the right way, I thought, and then we sort of lost focus and became pretty general.

And, you know, you would skip over some sections and then Dr. Fishman would go back to some sections. That's fine. But if he doesn't go back to some sections, I've got no testimony on them.

So I want you to both -- both of you, focus on exactly what you think is right or wrong with the guidelines. And if you don't, then the defense wins on those that you don't focus on.

Okay. Cross-examination.

CROSS-EXAMINATION

BY MR. RUTHERFORD:

Q. Good afternoon, Dr. Fishman.

A. Hello.

Q. You had testified about interactions you had with Dr. Danesh Alam; correct?

A. Uh-huh.

Q. This is somebody you have collaborated with in the past on studies; isn't that right?

A. That's correct. Dr. Alam and I have been coinvestigators on at least two that I can recall of such studies of medication treatment for addiction.

Q. And he's somebody you consider to be proficient at his work?

A. Yes. I know him as a scientist in doing pharmacological treatment of addiction. And he seems proficient, yes.

Q. And both professional and qualified?

A. For that, yes.

Q. You also mentioned a Mr. Jerry Shulman?

A. Uh-hum.

Q. Mr. Shulman is somebody that you've known for at least a couple of decades; isn't that right?

A. That's right.

Q. He's somebody that was contributing to the ASAM criteria prior to the time that you got involved, correct?

A. That's right. He's also a deputy editor. And his experience and work precedes my recruitment by Dr. Mee-Lee, correct.

Q. And you consider him to be a thoughtful person?

A. Yes.

Q. Someone who has a strong understanding of treatment placement guidelines?

A. Yes, that's right. Like any couple of experts, we might agree on some things and disagree on other things, but I think

of him as a thoughtful and proficient person.

Q. So you testified a moment ago about the concept of a least restrictive effective level of care. Do you recall that?

A. I do.

Q. Your critique of defense's exhibit of Dr. Simpatico was that he emphasized the restrictive aspect of that to the detriment of the effectiveness aspect of that; correct?

A. Correct.

Q. But you would agree that the least restrictive effective level of care is a concept that is consistent with the generally accepted standards of care when those two considerations are in balance; isn't that right?

A. Yes, that is correct.

Q. And you also testified that the applicability of restrictiveness was -- I don't want to put words in your mouth -- was either limited to involuntary situations or predominantly involuntary situations; isn't that right?

I mean, predominantly in involuntary situations.

THE COURT: No, he didn't say anything like that. Try again.

BY MR. RUTHERFORD:

Q. You mentioned the limitation of -- you testified that the concept of restrictiveness was limited to situations involving involuntary commitments.

THE COURT: No, that's not what he said.

If this is the way we're going to do cross-examination, we are going to have a very short cross-examination.

What he said was he criticized the other experts for drawing on involuntariness to justify having less restrictive conditions. That's all he said. So move on.

BY MR. RUTHERFORD

Q. Restrictiveness is a concept that applies across the continuum of levels of care; correct?

A. It can. It's most applicable to the highest levels of care, but it can apply to all levels of care.

Q. And that is both in terms of voluntary and involuntary levels of care; is that right?

A. That's right. So it can impose, say, burdens on a person at all levels of care, even if voluntary. But sometimes it also implies a needed ingredient to help protect patients and propel them towards good treatment outcomes.

Q. Now, when we began this morning, you talked about the various sources of generally accepted standards of care. Do you recall that testimony?

A. Yes.

Q. And you had mentioned, among others, the CMS, which is the Center for Medicaid and Medicare Services, which is a governmental organization?

A. Yes.

Q. And you mentioned CSAT, which is within SAMHSA, which is

also a governmental organization?

A. Yes.

Q. And articles written by colleagues of yours, who include Dr. Gastfriend?

A. Yes.

Q. There are also a number of other practice parameters that are in the marketplace that are -- that would qualify as generally accepted sources -- sources for generally accepted standards of care; correct?

A. Sure.

Q. Practice parameters promulgated by the American Psychiatric Association?

A. Correct.

Q. And as well as the -- what's termed as AACAP.

Are you familiar with the organization AACAP?

A. The American Academy of Child and Adolescent Psychiatry, yes.

Q. Correct. As well as the Commission on Accreditation and Rehabilitation Facilities, CARF, are you familiar with that organization?

A. CARF. CARF Commission might be another one. Many different ones, yes.

Q. So directing your attention to what has been marked as exhibit -- already marked as Exhibit 5 for identification, if you could pull that up.

And this is the 2015 Level of Care Guidelines.

A. I think that's here. Just a second.

Yeah, found it.

Q. So in response to questions that were asked by Mr. Goelman, you walked the Court through a number of sections within the 2015 Level of Care Guidelines; correct?

A. Yes.

Q. You walked him through the common criteria?

A. Yes.

Q. And that was for admission, continued service, and discharge?

A. Yes.

Q. As well as clinical best practices; correct?

A. Yes.

Q. So then directing your attention to Trial Exhibit 5, page 13-0013.

A. Yes.

Q. To the bottom portion of that, what looks like page 13 of the document and page 13 of the exhibit, do you see that?

A. I see that.

Q. And that indicates references, does it not?

A. There are references, yes.

Q. And these are references that are assigned to this particular level of care guideline; correct?

A. Yes, I see that.

Q. And in your review of other guidelines, you saw similar references to -- similar references to references; correct?
A. Yes.
Q. And this particular 2015 level of care guideline references the American Academy of Child and Adolescent Psychiatry and American Association of Community Psychiatrists, CA-LOCUS instrument; correct?
A. Yeah.
Q. And you're familiar with CA-LOCUS, are you not?
A. Some say yes.
Q. And that's another source of generally accepted standards of care?
A. Yes.
Q. As well as the American Academy of Child and Adolescent Psychiatry Practice Parameter in the Assessment and Treatment of Children and Adolescents; correct?
A. With suicidal behavior, yes.
Q. And that's another generally accepted standard of care; correct?
A. Yes. They may have different emphases than the ASAM criteria, but, yes, they all reflect components of documents that reflect part of the standard of care. I agree.
Q. And down to number 3, the American Association of Community Psychiatrists LOCUS instrument, you're familiar with that; correct?

A. Uh-huh.

Q. And that's another generally accepted -- source of generally accepted standard of care?

A. Or an articulation of what the authors have expressed of the generally accepted standards of care, yes.

Q. And then turning to page 14, at the top, there are four more references --

A. Uh-huh.

Q. -- as well. Three of them from the associations that you just mentioned. And the seventh is actually a reference to one of your works; correct? The ASAM criteria?

A. That I participated in, yes.

Q. And you are the MJ Fishman that's listed there; correct?

A. That's me.

Q. So, staying in this document for a moment, I'd like to direct your attention in this document to the guiding principles, so to Trial Exhibit 5, page 4. And that's both page 4 in the document and page 4 in the exhibit.

And this lists guiding principles, does it not?

A. Yes.

Q. And within guiding principles, there are three pillars that are listed; correct?

A. Yes.

Q. Directing your attention to the top of page 5, the second pillar is Service System Solutions. Do you see that?

A. I see that.
Q. And then the first sentence of the second paragraph, it sets forth a statement, does it not, about recovery, resiliency, and well-being. And that is, "We develop and sustain systems of care, including services to manage crises and to facilitate recovery, resiliency, and well-being." Do you see that?
A. Uh-huh.
Q. And you would agree that it's appropriate for patient placement consideration to take into consideration recovery; correct?
A. I do.
Q. And resiliency?
A. I do.
Q. And the well-being of the patient?
A. I do.
Q. So then turning your attention to Trial Exhibit 5, page 7, and that's both in the document and in the exhibit. And I'd like to direct your attention here to -- this is a section indicating use and limitations. Down to the fifth full paragraph.
A. Yes.
Q. Now, on direct testimony you had stated that the ASAM criteria does not purport to replace clinical judgment; correct?

A. Correct. Couldn't agree more.

Q. And isn't it true, as well, that the UBH criteria makes the same statement, that it does not purport to replace clinical judgment?

A. No, I agree. But my contention is that the UBH doesn't adequately guide clinical judgment within a structure and instruction set to give decision rules for proper placement.

Q. Right. But you recognize that the guidelines themselves indicate that they are to be used flexibly and are intended to augment but not replace sound clinical judgment?

MR. GOELMAN: Objection to form, Your Honor.

THE COURT: Overruled.

BY MR. RUTHERFORD:

Q. Now, directing your attention to page 10 of the exhibit -- and, again, that's 10 of the document and 10 of the exhibit -- it's entitled "Clinical Best Practices"; correct?

A. Correct.

Q. And you testified about the clinical best practices earlier today; correct?

A. Yes.

Q. Now, taking a step back, when you were describing the way that the ASAM criteria work, you described a process by which you began with collecting the information through the dimensions; correct?

And then, through those dimensions, formulating a

treatment plan, and then using that treatment plan determining a level of service?

A. Yes.

Q. Do you recall that testimony?

A. I do.

Q. So the UBH guidelines have somewhat of the same process, don't they?

MR. GOELMAN: Objection to form.

THE WITNESS: Well, I think there's something missing --

THE COURT: By the way, objection to form is not an objection under the Evidence Code.

MR. GOELMAN: Objection, compound, Your Honor.

THE COURT: Overruled.

THE WITNESS: Well, I think that there's something missing. I think that these clinical best practices section do direct a broad series of areas in which data should be collected. And I logged that.

But all of the material we've been talking about in these opening sections, in their general orientation to principle and here in the description of information to be gathered, I believe, don't adequately give instruction set and decision rules as to how to use these principles and information in actually assigning people to levels of care.

\\\

BY MR. RUTHERFORD:

Q. So let's walk through, now, beginning with section 4 on page 150 of Trial Exhibit 5.

A. Yes.

Q. Clinical best practices, as you testified earlier, guides the provider to collect certain information about the patient; correct?

A. Correct.

Q. And you would agree that the information that is listed here in section 4 is the type of information that is collected pursuant to clinically -- pursuant to generally accepted standards of care; correct?

A. I think it's a good list of material to be included in a data set, yeah.

Q. Then within the same section 4 on page 11 of that document, beginning at 4.1.4, the UBH guidelines then direct that that information be applied to a treatment plan; correct?

A. Correct.

Q. And then within the succeeding paragraphs on page 11, there are different pieces of guidance provided to the provider in order to formulate a treatment plan; correct?

A. What should those components be.

Q. Correct. And that information is then applied to the common criteria, is it not?

A. Well, it doesn't tell us how to use -- the common criteria

don't tell us how to use this material except in the ways that I've described as being overly restrictive.

Q. My question is different.

The treatment plan and the information are then -- are then considered within the analysis that is set forth under the common criteria for admissions criteria; correct?

A. This would be the data that would be considered to use the common criteria and the level of care specific criteria to apply decision rules, yes.

Q. Right. And, in fact, the admission criteria at 1.7, which is at the bottom of Trial Exhibit 5, page 0008, specifically require that that information collected under clinical best practices be considered; correct?

A. That they be considered. And the way that they are directing the user to consider them are in the specific language of the common criteria and the level of care specific criteria.

Q. And directing your attention to 1.7.3, one of the ways that they are to be considered is that they must be applied, quote, consistent with Optum's best practice guidelines; correct?

A. Yes. And it would be my opinion that the interpretation of how to do that is here on the page.

Q. Words on the page, though, read that the services are consistent with Optum's best practice guidelines; correct?

A. Uh-huh, yes.

Q. And that the services are consistent with generally accepted standards of clinical practice as well; correct?

A. Yes, that's right.

But to the extent that certain rules for how patients gain access to particular levels of care contradict the specific instruction set in the admission criteria, continued service criteria, and discharge criteria, I think that those would lead someone to say that those rules trump. And if that weren't clear, there would at least be an unresolved conflict.

Q. The admission criteria, under the common criteria and clinical best practices of all levels of care, require that the admission criteria, quote, be consistent with Optum's best practice guidelines; correct?

A. It does say that. And I'm only pointing out how I think that there's a contradiction.

Q. Now, turning your attention to the admission criteria, section 1.4, a little higher up on the page. Do you see that?

A. Yes, I see it, uh-huh.

Q. You testified earlier about aspects of 1.4 and as well as 1.5, which is just below it. Do you recall that testimony generally?

A. Yes.

Q. And you had indicated that one of your concerns, and certainly one of your overriding concerns with the guidelines,

is its focus on safety; correct?

A. No. It's on the overemphasis on safety without due consideration of effectiveness. I have no objection to patients being safe, I assure you.

Q. And in criteria 1.4, it states, does it not, that the member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors, i.e., the "why now" factors leading to admission.

That's what it states; correct?

A. Correct.

Q. And it gives no more weight in that sentence to "safely and efficiently" than it does to "effective"; correct?

MR. GOELMAN: Objection.

THE WITNESS: No, that's right. Here in this particular wording there isn't a differentiation made. There were other instances, that I think I pointed out, where the word "safety" appeared alone, without "efficiently" or "effectively." But I agree with you here, safely, efficiently, and effectively.

BY MR. RUTHERFORD:

Q. And that same would apply for 1.5 --

A. Yeah.

Q. -- below it?

A. That's right. As long as that is predicated on the treatment of the acute changes "why now" factors.

MR. RUTHERFORD: One moment, Your Honor.

THE COURT: Uh-huh.

BY MR. RUTHERFORD:

Q. Another one of your critiques of the 2015 Level of Care Guidelines was the emphasis on acuity, which you just spoke about, and a lack of emphasis on chronicity; correct?

A. Yes.

Q. So, focusing your attention back to page 11, which are the clinical best practices --

A. Yes.

Q. I mean, I'm sorry, page 10, which are the clinical best practices.

A. Yes.

Q. In terms of the information that is required to be gathered by the provider, a number of these factors speak to chronicity; correct?

A. Yes. Some of these factors could certainly have enduring persistence.

Q. So, for instance, the history of Behavioral Health Services; correct?

A. Correct.

Q. The history of trauma?

A. Correct.

Q. The member's medical history and current physical health status?

A. Correct.

Q. The member's developmental history?

A. Correct.

Q. The patient's pertinent current and historical life information, including the member's age; correct?

A. Correct.

Q. And gender?

A. Correct.

Q. Educational history?

A. Yes.

Q. On the next page, living situation?

A. Yes.

Q. Any number of these would speak to chronicity; isn't that right?

A. And I logged the collection of the data that is of complete history so that the data set is there.

My concern is that the decision rules that are applied to that data set don't sufficiently guide the proper emphasis and the use of the information that specifies chronicity and cumulative severity to influence the placement.

Q. So, again, back to the admission criteria on page 8 of Trial Exhibit 5, one of the requirements under the admission criteria is to consider, at 1.6, co-occurring behavioral health

and medical conditions; correct?

A. Correct.

Q. And, again, at 1.7.3, provide services consistent with the best practices guidelines; correct?

A. Correct. And so 1.6, although it mentions a co-occurring behavioral health and medical condition, which is completely appropriate, doesn't give us a way to understand what about the severity of those conditions and the treatment needs commensurate with those conditions would require placement at the current level of care other than that it would be safe to do so, which is good but not enough.

Q. But it's good; correct?

A. I want patients to be safe.

Q. Now, with respect to the mention of "why now," you had provided testimony earlier today, and we'll focus you on section 1.4, regarding "why now"; correct?

A. On page 8?

Q. I'm sorry, on page 8.

A. Yes.

Q. Thank you. 1.4 on page 8.

And you had also provided testimony earlier today regarding acuity; correct?

A. Yes.

Q. Now, the "why now" concept, which you testified is a potentially rich concept --

A. Agreed.

Q. -- could include information beyond acute factors; isn't that right?

A. It generally would focus on shorter-term acute and cross-sectional and crisis precipitant factors. Tell me what you mean.

Q. Well, so when you talked about it earlier -- when you testified earlier, you testified about the concept of motivation?

A. Yes.

Q. And what motivated a patient to come to me today?

A. Yes.

Q. As opposed to yesterday?

A. Yes.

Q. As opposed to tomorrow; correct?

A. Yes.

Q. And a patient could be presenting to a physician with the description of a chronic problem; isn't that right?

A. Well, it's interesting. Patients usually seek treatment because of something new. And that's one of the values of the "why now" concept clinically, as I described.

It's often part of the art of clinical therapeutic alliance to draw out of patients "why now," because they may sometimes say, well, I'm just chronically miserable or I've been like this or, as they may phrase it, I'm sick and tired of

being sick and tired.

But that doesn't have rich enough information to do the kind of motivational thing that I find valuable, which is to talk about why today. And so that is part of what does distinguish "why now" from enduring chronicity. And, as I said, both are vital.

Q. But it's also what distinguishes it from acuity, correct, because the "why now" requires the context of why now and not yesterday; isn't that right?

A. Yeah. That is the acute change.

THE COURT: Did you just say yes or no to that question?

THE WITNESS: I said that "why now" is the acute change and is different from the chronicity. And I apologize if I'm not remembering the question accurately enough.

THE COURT: Okay.

BY MR. RUTHERFORD:

Q. On direct examination you were asked a number of questions about lengths of stay. Do you recall that testimony?

A. Yes, I do.

Q. Now, the -- there has been an -- do you know the concept of a fixed length of stay?

A. I do know that concept.

Q. Isn't it true that there is an evolution away from fixed lengths of stay?

A. Yes.

Q. That that's too rigid a concept to appreciate the variety and complexity of conditions that a patient brings to a service; correct?

A. I agree. That's why a range is a much more useful tool.

Q. So, for instance, a treatment facility that would have a minimum 30-day stay, that would be inconsistent with generally accepted standards of care; correct?

A. Unless there were reason in a particular case to articulate and argue why that particular person needed a particular dose, a range would be relevant.

But something as specific as to say 30 days would not be consistent with generally accepted standards of care.

Q. Right. A range or an opportunity to adjust?

A. Correct. Because rigidity, I think, is not helpful, and flexibility is better.

Q. With respect to making placement decisions; correct?

A. With respect to lengths of stay.

Q. Now, with respect to the promulgation or the introduction, I guess, of the word "why now" in the Level of Care Guidelines, you don't know what UBH's purpose was in including the "why now" concept in the Level of Care Guidelines; correct?

A. I can't speculate as to motive. I can only tell you what I read in the instruction set. But I don't know what the authors were thinking at the time.

Q. Now, changing gears a little bit here, with respect to the opinions that you're rendering, just to be clear, you had mentioned earlier today some ideas that you had that might change the language -- if the language of the guideline were changed, then you might be more comfortable with it?

MR. GOELMAN: Objection. Misstates his testimony.

THE COURT: He can answer.

BY MR. RUTHERFORD:

Q. Do you generally recall that testimony?

A. Today?

Q. Yes.

A. I don't, but I can answer. I can say that --

THE COURT: Why don't you have him ask a specific question.

MR. RUTHERFORD: I'll ask it differently, Your Honor.

THE WITNESS: Okay.

BY MR. RUTHERFORD:

Q. You're not here to opine regarding specific changes that need to be made in the UBH Level of Care Guidelines; correct?

A. Correct. That was not my scope, to rewrite them. I am only commenting on ways in which they are consistent or not consistent.

And I may have given some general information about where I think there ought to be movement. And it may even, in our conversation, have gotten to the specifics of a particular

word. But, again, that was not the scope. And I don't think that any one or even several words or wordsmithing accomplishes the task.

Q. Now, you understand that the scope of coverage for benefits for -- both for the substance abuse disorders that you've discussed and for mental health treatment is contained in health benefit plans for the members at issue in this case; correct?

A. It may vary.

Q. And you didn't review the health benefit plan documents in preparation for trial today?

A. I did not.

Q. And so you're not offering an opinion on any of the language that might or might not be in those health benefit plans; correct?

A. Correct.

Q. And you don't have information regarding whether or not plan restrictions cover, for instance, residential treatment; correct?

A. I don't have that information.

Q. Or whether health plans in this case have a particular definition of custodial care; correct?

A. I don't have that information.

Q. Or whether specific plans in this case exclude treatment that's primarily court ordered or for legal purposes; correct?

A. I don't have that information.

I only have information about how the generally accepted standards of care are consistent or not with such exclusions, and that a set of criteria that purport to be a standard instrument for decision-making should or should not contain those elements.

Q. So back to Trial Exhibit 5, at page 8, under the admission criteria, directing your attention to 1.1, you understand that the first factor that is considered when determining whether the criteria is met is whether the member is eligible for the benefits; correct?

A. Makes sense.

Q. And there may be some benefits that are not available under the plan?

A. Contractually. Makes sense.

Q. Correct. So now directing your attention to Exhibit 148, which should be in the binder that you had earlier with Mr. Goelman.

A. Okay.

Q. And now directing your attention within that document to page 3, Trial Exhibit 3, but it says 2 of 8 on the document itself.

A. "Key Points," yes.

Q. And you provided some testimony this morning regarding custodial care, and specifically the fourth point under that --

I mean, the third point under that provision: "Services do not require continued administration by trained medical personnel in order to be delivered safely and effectively."

Do you see that?

A. I do.

Q. Now, looking above at the first large bullet point, it references something called a certificate of coverage.

A. I see that.

Q. And you understand that a certificate of coverage is one of the documents in the health benefit plan; correct?

A. Okay.

Q. And you understand that this is a definition set forth in the certificate of coverage; correct?

MR. GOELMAN: Objection. Foundation.

THE COURT: Sustained.

BY MR. RUTHERFORD:

Q. Well, do you know one way or the other?

A. I don't know.

Q. You also don't know how, with respect to custodial care, the health benefit plans document -- the health plan documents in this case define custodial care; correct?

You don't know what that definition is, do you?

A. I wouldn't know the variations of the individual plans. But to the extent that there are benefits that are covered, it's my surmise that this should guide how the clinical

treatment needs of patients should or should not be allowed to the extent that this document is used as a set of instructions to make that determination.

Q. Well, you understand that the custodial care coverage determination guideline here at Exhibit 148 would only apply if it's consistent with a particular health benefit plan; isn't that right?

A. Makes sense.

Q. And if I direct your attention then to instructions for use, on Trial Exhibit 148, page 0002, in the second half of the first full paragraph, it sets forth, does it not, that the terms of an enrollee's documents, e.g. the Certificates of Coverage, COCs, Schedule of Benefits, SOBs, or Summary Plan Descriptions, SPDs, may differ greatly from the standard benefit plans upon which this guideline is based?

In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or is, therefore, otherwise a conflict between this document and the Certificate of Coverage, COC, or Schedules of Benefit, SPD, that the enrollees -- I'm sorry, that the Summary Plan Descriptions, the SPD, the enrollee's specific benefit document supercedes these guidelines.

A. All right. That makes sense. But let's hypothetically say --

THE COURT: Well, let's just let him ask the question.

THE WITNESS: Fair enough.

THE COURT: Don't squabble.

THE WITNESS: Okay.

BY MR. RUTHERFORD:

Q. Now, you also testified on direct examination about certain Texas regulations; correct?

A. Yes.

Q. That was in connection with -- I believe it was Exhibit 570.

You didn't investigate -- I'm sorry, that's the wrong one.

MR. RUTHERFORD: One moment, Your Honor. I wrote down the wrong exhibit number.

BY MR. RUTHERFORD:

Q. Dr. Fishman, I'll ask you the question without the exhibit.

A. Okay.

Q. So you testified earlier today about various ranges of length of stay within the Texas Department of Insurance Guideline; correct?

But you didn't investigate whether UBH uses the guidelines in the state of Texas, correct, or for plans based in the state of Texas?

A. No, I wouldn't know that. Only the guidelines as written in both cases, the UBH guidelines and the Texas guidelines.

Q. Right. So you're not opining on whether UBH is required

to use the Texas guidelines in Texas or not required to use the Texas guidelines in Texas?

A. Correct. Nor whether UBH's length of stay data comes from Texas or not. Only that I was -- I had seen UBH length of stay data that was shorter than the recommendations, but I wouldn't know from where.

MR. RUTHERFORD: One moment, Your Honor.

BY MR. RUTHERFORD:

Q. Now, on direct examination you were also asked some questions about child and adolescent care.

A. Yes.

Q. Child and adolescent care is different from the care of adults; correct?

A. Many aspects of it are different, yes.

Q. And one of your criticisms of the Level of Care Guidelines for 2015 was its absence of specific criteria that set forth either information gathering, treatment plans, or the application of criteria for child or adolescent members; correct?

MR. GOELMAN: Objection. Misstates his testimony.

THE COURT: That's correct. Go ahead.

BY MR. RUTHERFORD:

Q. Now, directing your attention back to Trial Exhibit 5, page 9 -- I'm sorry, page 10.

Now, under clinical best practices there are a number of

questions, again, that the provider is required to ask of a patient when the patient has presented him or herself; correct?

A. Correct.

Q. And in order to -- I guess one of those at 4.1.2.13.1 is the member's age; correct?

A. Yes.

Q. As well as 4.1.2.12, which is the member's developmental history; correct?

A. Correct.

Q. And then, turning to the next page, the provider is requested to inquire as to the patient's living situation; correct?

A. Correct.

Q. Family history?

A. Correct.

Q. Relationships with family, friends, and others; correct?

A. Correct.

Q. Barriers to care?

A. Correct.

Q. Okay. All of which, with an adolescent or a child, would elicit information different from information that would be getting elicited from an adult; correct?

A. That's right. So the information gathering here might be able to pertain to youth, adolescents, young adults, and the like, but wouldn't direct a person, a user, how to specifically

use that data set to make the differential kinds of treatment recommendations and specifically level of care placement decisions that adolescents would need that are different from adults.

Q. And in the clinical best practices section, as we discussed earlier, there is a requirement that a treatment plan be devised; correct --

A. Correct.

Q. -- based upon the clinical information provided by the member?

A. Correct.

Q. That takes into consideration each of the factors that I just mentioned; correct?

A. Correct.

Q. And is individualized; correct?

A. Correct.

Q. Because it's not a cookie-cutter treatment plan; correct?

A. I would hope not.

Q. Right. And then that is then provided to UBH and applied to the criteria by one of the UBH clinicians; correct?

MR. GOELMAN: Objection. Your Honor --

THE WITNESS: As --

THE COURT: Wait. There's an objection.

MR. GOELMAN: Foundation.

THE COURT: Sustained.

BY MR. RUTHERFORD:

Q. As articulated by the document itself; correct?

MR. GOELMAN: Same objection.

THE WITNESS: Well, the rules for placement would be articulated in the admission criteria, the continued service criteria, and the discharge criteria.

BY MR. RUTHERFORD:

Q. Right. And the admission criteria require that the UBH clinician take into consideration the information gathered through the clinical best practices; correct?

THE COURT: Have you got a citation for that?

MR. RUTHERFORD: 1.7.

THE COURT: That doesn't say that. That just says it has to be consistent with the information.

BY MR. RUTHERFORD:

Q. So the services need to be -- there needs to be a determination made, correct, that the services are consistent with the clinical best practices of Optum; correct?

A. But we're back, for me, to the same contradiction with the specific rules of what the admission criteria are and the potential conflict.

THE COURT: Putting an awful lot of emphasis on that 1.7.

BY MR. RUTHERFORD:

Q. Now, directing your attention to what was previously

marked and admitted as Exhibit 662, specifically to page 137 of Exhibit 662, which is the ASAM criteria.

A. Hang on one sec. Yes.

Q. Do you have that in front of you?

A. I do. What page -- you want page 137?

Q. Of the exhibit, Dr. Fishman, I would direct your attention to page 0137, and of the document itself, 116.

A. Yes.

Q. Second full paragraph, beginning with the word "similarly"?

A. Yes.

Q. The ASAM criteria contains a section, as you testified earlier, on adolescent-specific approaches to sub levels of care?

A. Uh-huh.

Q. Correct?

A. Yes.

Q. That's the title at the top of that section?

A. Yes.

Q. And the second full paragraph indicates: "Similarly, the definition of intensive outpatient services refers to a minimum of six hours of treatment per week for adolescents as opposed to nine hours per week for adults."

A. Yes.

Q. "The difference reflects the developmental and attention

capacities of adolescents for whom six hours of treatment, generally delivered in two sessions of three hours each or three sessions of two hours each, falls more closely within the spectrum of Level 2 intensive outpatient services than Level 1 outpatient services."

Do you see that?

A. Yes.

Q. Now, directing your attention to Exhibit 7, page 0062. And this is a 2016 UBH Level of Care Guideline.

A. Okay.

Q. Do you have that in front of you?

A. I do.

Q. This is the intensive outpatient program for substance-related disorders, the 2016 Level of Care Guideline; correct?

A. Yes.

Q. And as you can see in the first paragraph, much like the ASAM criteria, it sets forth specific hours and differentiates between the hours of service for adults and the hours of service for children and adolescents; correct?

A. Correct.

Q. It indicates that, "A structured program that maintains hours of service generally 9 to 19 hours per week for adults and generally 6 to 19 per week for child and adolescents during assessment and diagnostic services and active behavioral health

treatment provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues."

Do you see that?

A. I do.

So here's a way that the difference is taken into account but the decision rules don't take into account the way that the decision to get into the level of care with either the six-hour threshold or the nine-hour threshold would be different.

Q. The hours differentiation is similar between ASAM and the UBH criteria; correct?

A. Correct.

Q. And the UBH criteria do specifically delineate a range of hours for children and adolescents that's different from the range for adults; correct?

A. That is correct.

MR. RUTHERFORD: One moment, Your Honor.

BY MR. RUTHERFORD

Q. Now, directing your attention to Trial Exhibit 5, page 70, which is the 2015 Level of Care Guidelines. And it's the section on outpatient Substance-Related Disorders.

Do you have that in front of you?

A. I do.

Q. And you testified this morning about section 1.4 of this particular guideline. Do you recall that testimony generally?

A. I do recall that generally.
Q. And you indicated during that testimony that this guideline implies that when the acute signs and symptoms end, treatment ends; correct?
A. That the emphasis is on those acute symptoms, and that when they are reduced -- when those signs and symptoms are reduced, the user is directed to think -- is directed to think that there is less rationale, yes, for that level of care.
Q. That's how you're reading it; correct?
A. It is.
Q. That is an implication that you have drawn in your analysis of that section; correct?
A. Well, they are connected by "and," so I don't think it's a big stretch. So my read and, I think, a read that many would take, or most would take, is that it is acute changes and changes in psychosocial environmental factors have occurred.
Q. Did you conduct a survey on what many people would read that language to be?
A. I can only --
MR. GOELMAN: Objection.
THE WITNESS: I can only tell you what it says. I'm reading English here.
BY MR. RUTHERFORD
Q. So you didn't inquire as to what most people would think as part of forming your opinion for today's testimony; correct?

A. Poll-taking was not part of my scope, no.

Q. This is your opinion as what the language says; correct?

A. It is my opinion about what this says, yes.

MR. RUTHERFORD: Your Honor, I may be close to concluding if I could just take a look at my notes.

THE WITNESS: Okay.

MR. RUTHERFORD: I'm sorry, Your Honor. I seem to have lost my one exhibit that I've been using. Give me like -- it's here someplace.

THE COURT: Find it. That's fine. Okay.

BY MR. RUTHERFORD:

Q. Okay. So now directing your attention to what has already been admitted as Trial Exhibit 6.

A. Yes.

Q. And specifically page 10 of the trial exhibit, page 10 of the document.

A. 2016; correct.

Q. 2016. If I said 2006, I misspoke.

A. No, no. Just to clarify.

Q. And the 2016 Level of Care Guidelines are another one of the documents that you reviewed in preparation for your testimony today; correct?

A. That's correct.

Q. And like the 2015 Level of Care Guidelines, the 2016 Level of Care Guidelines contains a section on common criteria and

clinical best practices?

A. Correct.

Q. And within that contains admissions criteria; correct?

A. Yes.

Q. Continued service criteria?

A. Yes.

Q. Discharge criteria?

A. Yes.

Q. And clinical best practices?

A. Yes.

Q. And within the continued service criteria it indicates, does it not, that the -- under 2.1, that "The admission criteria continue to be met, and active treatment is being provided. For treatment to be considered active, services must be as follows." And 2.1.2 provides, "Provided under an individualized treatment plan that is focused on addressing the 'why now' factors and makes use of clinical best practices."

Do you see that?

A. I do.

Q. And that clinical best practices refers to the clinical best practices on page 11 of the same document, does it not?

A. It does.

Q. And the treatment plan that is promulgated through the clinical best practices under section 4, on page 11, are the same document; correct?

A. Yes, as long as "why now" factors continue to be met and the focus is on the reduction of acute symptoms.

Q. And then further down in that same section, at 2.3, the 2016 Level of Care Guidelines indicate, do they not, the clinical best practices are being provided with sufficient intensity to address the member's treatment needs; correct?

A. Correct.

MR. RUTHERFORD: One moment, Your Honor. I think I might be done.

One more question, Your Honor. I do have one more question. I just need to find it and I'll be finished, Your Honor. So beg your indulgence.

BY MR. RUTHERFORD

Q. So now directing your attention to, finally, Dr. Fishman, to Exhibit 662, page 0131. This is the ASAM criteria of which you are one of the authors; correct?

A. Page which?

Q. Page 110 within the document. It's going to be page 0131 within the exhibit.

A. Yes, I'm there.

Q. The title paragraph in the upper right-hand corner of this page is Progress Through Levels of Service?

A. Yes.

Q. Do you see that?

A. Yes.

Q. And then there's a call-out. That's what I call it, but a sort of section in different formatting just under that. Do you see that?

A. I do.

Q. And in the third paragraph of that section, it reads as follows: The -- and correct me if I'm wrong.

"The ASAM criteria multidimensional assessment helps ensure comprehensive treatment. In the process of patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care. The resolution of those problems and priorities determines when a patient can be treated at a different level of care or discharged from treatment."

That's what it states; correct?

A. Uh-huh. Yes. And it goes on to say that the appearance of new problems may require services that can be effectively provided at the same level of care or require more or less intensive levels.

MR. RUTHERFORD: Correct.

No further questions, Your Honor.

MR. GOELMAN: Your Honor, may I have one moment to confer with my colleagues about redirect?

(Pause)

REDIRECT EXAMINATION

BY MR. GOELMAN:

Q. Dr. Fishman, you were asked on cross-examination about what the generally accepted standards of care say when effective and least restrictive are in balance. I think that was the question. Do you recall that?

A. I do.

Q. In your 25 years of practice, how often have you seen cases where effective and least restrictive are perfectly in balance?

A. That's right, it's a hypothetical that may rarely occur. But it's certainly infrequent. I think that what typically drives decisions are most -- what typically drives decisions are most effective.

So if they were in exact balance and two levels of care were identically effective, it would make sense to choose the lesser restrictive because of the burdens that it might confer.

But usually it is that one is likely to be more effective, or the hypothesis is that one is more likely to be effective, and that's the one that you choose and try.

Q. Do the generally accepted standards of care say which value, effectiveness versus least restrictive, trumps when there is a conflict?

A. Yes. In general, the approach is, if the most effective level of care is not available or there's a gray area between two levels of care, one should take the conservative position and round up, as it were, or go to the next highest level of

care.

But even that is not as important as trying to make the determination in clinical judgment of what is the most effective.

THE COURT: So let me ask you a question.

Isn't that a false dichotomy?

THE WITNESS: Ask again?

THE COURT: Isn't that a false dichotomy?

Isn't part of effectiveness in evaluation of the restrictiveness of the setting, the restrictiveness of the setting will have positive effects or it will have negative effects on the patient and on the treatment of the patient, and it's taken into account in deciding effectiveness?

THE WITNESS: Point well taken. I think that's well put. And so, in that way, effectiveness sometimes counts towards your clinical aims and sometimes counts against your clinical aims. And then they're best when integrated in the way you describe. I agree with that.

BY MR. GOELMAN:

Q. You were shown Trial Exhibit 5. I think it was page 13. It's a list of sources that were cited, Practices. Do you see that?

A. I do.

Q. And counsel asked you some questions about these references and the organizations that were behind these

references.

Do you know whether these references actually support the guidelines that they purportedly are cited for?

A. Well, I think putting these in a bibliography doesn't tell us the ways in which the information was incorporated, so just because they're cited doesn't mean that they're followed.

I don't think that the UBH guidelines are consistent with the LOCUS and CALOCUS either, but that was outside of the scope of the conversation.

The practice parameter for the assessment and treatment of children and adolescents with suicidal behaviors would have some but not a lot of intersection here and might focus on areas where there is high acuity, and there I think that there would likely be permissive consistency; that is, if there was dangerousness, if there were suicidal youngsters that needed a level of care, I think that this probably gives information but I don't think, for example, as I've discussed at the citation for the ASAM criteria imbues this with the authority of the ASAM criteria. And we've been discussing at length the ways it is inconsistent with the ASAM criteria and I think putting it in a bibliography doesn't make it not so.

Q. You were asked a number of questions about the best practices section of the guidelines -- I think it was in Exhibit 5 for 2015 -- and you were also asked --

MR. GOELMAN: Can you bring up the first page of the

common criteria for 2015?

THE WITNESS: That's Number 5, I think.

BY MR. GOELMAN:

Q. Yeah, Number 5 and it's page 8. There it is.

A. Yeah. So the best practices are 10 and 11.

Q. Yeah. And you were asked a number of questions about I think it was Section 1.7.3, which says "Consistent with Optum's Best Practice Guidelines." Do you see that?

A. I do.

Q. You noted earlier that the word "and" appears in between each of these sections?

A. Yes.

Q. And what does that signify to a reader?

A. Well, it signifies that it wouldn't be enough that 1.7.3 is met but the others would also have to be met, and that's the reason why I continue to say that it's the admission criteria as instruction rules for placement that are so critical to assessing whether or not it's consistent with generally accepted standards of care; but it would have to be that it meet these criteria as well is what it means.

Q. So if a provider had done a great job complying with the best practices and gotten information about every detail of a patient's life, would that help that patient get coverage if that patient didn't comply with each and every one of the other sections here?

A. They would still have to --

MR. RUTHERFORD: Objection, Your Honor. Compound.

THE COURT: Overruled.

THE WITNESS: No matter how good the richness of the information gathered, the decision rules about access to the level of care and the pathway to get coverage for a level of care come from the other criteria connected by "ands."

BY MR. GOELMAN:

Q. Dr. Fishman, what I now hope to do is to just have you walk through the core -- the common criteria and the applicable criteria for IOP, OP, and residential treatment for the years that we didn't focus on them earlier.

MR. RUTHERFORD: Objection, Your Honor. Beyond the scope.

THE COURT: Overruled.

BY MR. GOELMAN:

Q. So I want to start with I think it's 2012, which would be Trial Exhibit 2.

A. Exhibit 2?

Q. Yeah. And, Dr. Fishman, to the extent that you see identical verbiage in the sections here that you have pointed out in other years, there's no need to go back into the substance of your criticism. You can just point that out. Thank you.

A. Okay. (Witness examines document.)

Q. Looking at Exhibit 2, page 006, do you see the common criteria which argues for all levels of care for mental health conditions and for substance use disorders?

A. I do.

Q. And it says (reading):

"These criteria should be used in conjunction with the criteria for the current level of care."

A. That's right. So they would be combined with the level of care specific criteria further on.

Q. Do you see anything in here that is identical or substantially identical to the common criteria from 2011, Dr. Fishman?

A. I think 6 is problematic. Again, there's the focus on the reasonable period of time, the clock is ticking. We have discussed this. And the definition of reduction or control of the acute symptoms that necessitated the admission as the definition of "improvement."

Q. And consistent with your testimony about years 2011 and 2015, is that consistent with generally accepted standards of care?

A. It is not. And, again, whereas there's lip service paid to the prevention of deterioration, it's my concern that the context is defined here as control of acute symptoms.

Q. Okay. What about criteria 7?

A. Again, it narrowly defines the goal of treatment as

improving the member's presenting symptoms, which has similarity to the later-introduced phrasing for "why now" but, again, focuses on crisis and precipitating presentation, and I think that that's narrow as discussed before.

Q. And does criteria 8 -- criterion 8 include the language that you objected to earlier regarding antisocial behavior and legal problems?

A. It is essentially the same concept and would exclude what I think is much needed treatment for antisocial or legal problems if for a particular person they were central to the pathology of a substance use disorder.

Q. If you want to call the Court's attention to anything else that you see in the common criteria in 2012 that is inconsistent in your opinion of generally accepted standards, please do.

A. Number 10, "treatment plan stems from the member's presenting condition," that's good but it should not be sufficient. It could also stem from nonacute, nonpresenting chronic issues.

(Witness examines document.) Those are my comments.

Q. Sorry?

A. Those are my comments.

Q. Okay. And can you look at the continuing stay criteria also part of the common criteria for 2012?

A. I think there's a separate section, if I recall correctly,

at the end and that would be on page --

Q. 81?

A. -- 81.

Q. Or Trial Exhibit 2-0082.

A. 82.

Q. And so we saw something similar to this in 2011 guidelines, did we not?

A. That's correct.

Q. Are the aspects of the continuing service criteria that in your opinion were inconsistent with generally accepted standards of care in 2011 also present in the 2012 version of the same section?

A. (Witness examines document.) In Number 5, the reasonable expectation of improvement, I remain concerned that these criteria don't sufficiently emphasize the broad definition of "improvement" that includes prevention of deterioration.

I do like that there is mention to addressing interventions to engage.

Q. What about criteria 6 where current symptoms and/or history provides evidence that relapse or a significant deterioration in functioning would be imminent if the member was transitioned to a lower level of care?

A. Yeah, I think the emphasis on the time course of imminent is appropriate for higher levels of care but it is inappropriate for lower levels of care; and so for the lowest

levels of residential care and for outpatient levels of care, that deterioration would not necessarily have to be imminent as in hours to days.

Q. So if you are a substance use disorder patient and you still had the underlying condition, would it be within the generally accepted standards of care to discharge you unless a significant deterioration was imminent?

A. No. It ought to be broader that a significant deterioration in functioning was predictable, but it is too restrictive to require it to be imminent.

Q. Okay. Anything else in this list of criteria, Doctor?

A. (Witness examines document.) No. Those are my comments.

MR. GOELMAN: All right. Do we have the discharge or --

(Pause in proceedings.)

BY MR. GOELMAN:

Q. So let's turn to the residential guidelines for 2012.

A. Can you direct me to the page?

Q. I would love to.

A. (Witness examines document.) Page 61.

Q. So for the record that's Trial Exhibit 2-0062, also page 61 on the internal pages.

And is that the residential rehabilitation guideline for substance use orders for 2012?

A. Yes.

Q. It seems to have similar structure to the guideline that we looked at from 2011.

A. Correct.

Q. Please point out any substantially identical language or other portions of this guideline that inform your opinion that this guideline does not conform with generally accepted standards here?

A. The language is not exactly the same, but as I've discussed, I think these individual criterions -- criteria overemphasize the extent to which treatment in a lesser level of care would have to be deemed not safe, and I would recommend a broader standard of not effective.

So Number 1, use of substances with deterioration to the point that a member cannot safely be treated in a less restrictive level of care but it needs to be "safely and effectively."

Risk of exacerbating a serious co-occurring medical condition in Number 2 and cannot safely be treated in a lower level of care rather than "safely and effectively."

The absence of the corresponding co-occurring mental health or psychiatric condition that we saw in another year.

The emphasis in Number 3 on the high risk of harm to self or others. So it's pushing the threshold to the standard of lethality or approaching that rather than thinking about broader deterioration, risk of relapse, and risk of functional

problems.

Number 4, again, "safely" rather than "safely and effectively."

Number 5, "safely" rather than "safely and effectively" as relates to Dimension 1 withdrawal and withdrawal management.

(Witness examines document.) In Number 2a, this is exactly the same language that we saw before requiring the role of a psychiatrist or addiction physician even in lower levels of residential care that would not under generally accepted standards of care be usually or typically required to have medical supervision or medical service delivery.

Number 3, the implication that psychiatric, that is -- or addictionology, that is, medical services are available at this level of intensity, that would be appropriate for 3.7 but it would not be appropriate for 3.5, 3.3, and 3.1. That is the ASAM numbering for the lower levels of residential care.

(Witness examines document.) For Number 4, whereas it would be reasonable -- and I don't want to nit-pick too much. When it says that they are available, oftentimes medical services might be available by referral, but to imply that they would be provided through the program is too restrictive again for the lower levels of residential care that would not be expected to have their own medical services.

5, as we've discussed before, the choice between an every five-day review versus this higher standard of compelling

evidence, which is hard to know how to meet and gives the impression that we're looking for reasons to not allow access to the treatment level of care.

Number 5a gives a different way in which the broad basis for the definition here of custodial care I think is overly broad.

I would say that there is an exclusion that is concerning to me. Especially for youth treatment, interventions are excluded or considered custodial if they are solely to prevent runaway, truancy, or legal problems. And for some youngsters with SUD and concurrent psychiatric problems, their inability to sustain stable living situations, their running away puts them at enormous risk and exposes them to a variety of dangers. They may be trafficking drugs. They may be victims of violent crime. They may be not able to care for themselves. They may be trading sex for drugs. And that is often central to the treatment goals of a particular level of care, and to make a distinction and a false dichotomy away from active treatment that is central to SUD treatment I think is not consistent with the generally accepted standards of care.

And I've talked about legal problems before sometimes central.

The presenting signs and symptoms have been stabilized is again an overly broad definition because there may be chronic nonpresenting signs and symptoms that still pertain and are

still responding to treatment or could respond to treatment with further effort.

Q. I'm sorry. Where are you Dr. Fishman?

A. I'm now on 5a, little ii.

Q. Okay. I just wanted to make sure.

A. No, that's not right. 5a, small i is what I was talking about.

5b again narrowly constrains the consideration of residential care to only the highest level of residential care, the medically monitored levels of residential care numbered 3.7 by the ASAM criteria. Again, it doesn't matter how you number them, but that not all residential levels of care -- most especially, say, 3.1 but also 3.3 and 3.5 -- would not be medically monitored or supervised or directed.

Those are my comments.

Q. Okay. Let's turn to the guideline for intensive outpatient, IOP, for 2012, which is Trial Exhibit 2-0047.

A. (Witness examines document.)

Q. Again, it appears to be at least substantially similar to the 2011 version but, Dr. Fishman, if you could go through there and identify, again, substantially verbatim sections or other sections that you believe supports your opinion that the IOP guideline for 2012 violates generally accepted standards of care.

A. Okay. I think that Number 1 leads the user to make

decisions about alternative lower levels of care only on the basis of safety but not on the basis of being effective. We've discussed that concept before. Here it is again.

Number 2 focuses the user to think of the purpose of this particular level of care, IOP, as being to prevent admission to a higher level of care, say residential treatment or hospital, and that is not by any means the only or even the main purpose of this level of care.

"Imminent" is too restrictive. Number 3, "imminence of relapse" is too restrictive, a modifier for the likelihood of relapse. I agree that it's an appropriate pathway to think about the likelihood of relapse if treatment is not provided, but "imminent" is too strong a term or restrictive a term.

(Witness examines document.) 4 is a reasonable pathway from stepdown. I have no objection.

(Witness examines document.) And 5, we've discussed this before.

It's good that there is consideration of Level 6 recovery environment, home environment, living situation factors, but it's overly narrowly construed to require that they be a nonsupportive or unstable living situation because there might be situations that it's not so much that there are problems with the home but there are problems or vulnerabilities of the person that is unable to make use of or even openly opposes or rejects that support, and I would want to reject that as well.

Q. Dr. Fishman, I think you may have misspoken. You said something about Level 6. Did you mean Dimension 6 of ASAM assessment criteria?

A. I apologize. That was an error. That would be Dimension 6, recovery environment. There is no Level 6. Thanks for catching that.

Q. And just referring back to the list of criteria which follow the clause "any one of the following criteria must be met," are there patients who, in your professional opinion, should qualify for intensive outpatient that would meet none of those five criteria?

A. Yes, I do, and it's similar to a case that we talked about before. By omission we don't see sufficient emphasis on co-occurring psychiatric or mental health disorders. A person who has had worsening, say, of a concurrent depression or a concurrent psychosis, it wouldn't be that they would not be safe but that they would be at risk of relapse; and that is a person who would need the intensity of services at this level of care, the increased dose, the frequency of monitoring, the support for depression, treatment, adherence. And this set of five criteria would not provide a pathway in.

Q. Okay. And then there is a list of criteria all of which are required to be met.

A. I see that.

Q. Okay. Can you go through the same exercise with these

criteria, Dr. Fishman?

A. (Witness examines document.) So for 3 and 4, again, we have said that if they are not safe at this level of care, that we wouldn't want to include them and we'd want to jump to a higher level of care. That's certainly laudable, but we're missing the reasons especially for a co-occurring mental health condition because co-occurring medical is mentioned in the section above but co-occurring mental is not.

One of the reasons of severity and treatment needs that a person would be matched to this level of care for, not just what they would be excluded for but why they would be included, and we want to see that -- as in the case I described of a person with chronic but exacerbating depression, we would want to see that as a pathway in and that's absent.

In Number 5, this is essentially similar language in another year we looked at, that the family can comply with the requirements of an IOP or the member is likely to participate. Again, we wouldn't require motivation or adherence on either the part of the family or the member. That would be a goal of treatment.

We would expect that there would be some people with low motivation, even frank opposition to treatment, either at the level of the family or the patient. That should not be an exclusion. It should be, rather, grounds for the use of motivational enhancement treatment techniques.

If it were -- Number 6, if it were what we call a co-occurring disorder enhanced or specialty dual diagnosis program, it might certainly have a psychiatrist that would do a comprehensive evaluation within three days, but that shouldn't be at this nonmedical level of care a requirement. It creates a barrier to access in a way that would not be typical of all iterations or appropriate all iterations in this level of care.

Q. Is that true with the other time limits, the treatment plan with inclusion of mild recovery within the first eight sessions, within the first -- following the 48 hours of admission, the contact of recent provider and family members?

A. I don't object to those as strongly. Those don't require that they be medical providers. Eight sessions is not so unusual, and the attempt to contact the member's family and the outpatient provider is not unduly unreasonable.

Q. Okay.

A. (Witness examines document.) Though in 8, again, there is a time clock that I think is overly restrictive and it reminds me of the paragraph that we were looking at previously in the ASAM criteria. Three to five treatment days is probably only two or three, at most, sessions of IOP. That's probably too frequent and is overly burdensome and, therefore, creates a barrier to access to require a formal treatment plan review at that level of frequency. Every two or three weeks I think would be more reasonable and more consistent with generally

accepted standards of care.

And here, again, the alternative is this very high level of evidence, which I don't know what the medical definition of is, but compelling evidence seems like it says to the user, "This is unlikely to be accepted unless it's that compelling," whatever "that" is.

Q. Dr. Fishman, you referred in your answer to that question to a paragraph that we'd been looking at in ASAM?

A. Yeah, that's right. I thought that at Trial Exhibit 662-0131, that I just by accident happen to have still open, there's a definition of the appropriate frequency of treatment reviews about every six sessions; and as that applies to IOP, the recommendation is approximately two weeks.

Q. Okay. So that's the way that this guideline is inconsistent with ASAM?

A. Correct.

Q. Okay. Please go on.

A. (Witness examines document.) Those are my comments.

Q. Okay. Let's go to outpatient 2012, Trial Exhibit 2-0051.

A. Yeah. My main objection here is identical to the one that we looked at in 2011. It's Number 2. The requirement that lapse has occurred or is imminent as a criteria for outpatient treatment at this lower, less intensive level of care, as I've discussed; indefinite maintenance treatment, even lifelong maintenance treatment despite stabilization as a method of

preventing relapse without it actually having occurred as a method to continue support for stability despite the absence of symptoms or lapses I think would be consistent with the accepted level -- accepted -- the generally accepted standards of care, and this is inconsistent.

MR. GOELMAN: One moment, Your Honor.

(Pause in proceedings.)

BY MR. GOELMAN:

Q. Let's move on to 2013 and start again with the common criteria. I think this is Trial Exhibit 3.

A. Exhibit 3.

THE COURT: Okay. So we're stopping at 4:00. Figure out how you want to do that.

THE WITNESS: Uh-huh. Same exercise?

BY MR. GOELMAN:

Q. Yes, sir.

A. So in the common criteria beginning on page 6 or 3-0007, 3a overemphasizes -- oh, no. I'm sorry. This is collecting information. That's okay. My apologies.

(Witness examines document.) Number 7 is the same distinction that we've made between the definition of "improvement" that is narrow and does not adequately include prevention of deterioration and maintenance of function. The metric used is the reduction or control of the acute symptoms that necessitated treatment, and the nod to prevention of

deterioration is still predicated on the context in my read of the control of acute symptoms.

Number 8, again, the goal treatment is to include the presenting symptoms rather than also including chronic, enduring, and persistent and cumulative symptoms that still continue to present severity and treatment need for a particular level of care.

Number 9, the same language. There's an exclusion for the addressing of antisocial behavior or legal problems. No need to discuss that all over again.

(Witness examines document.)

Q. So go back up to criterion 6, please. I'm not sure that this verbiage is familiar (reading):

"Member's current condition cannot be effectively and safely treated in a lower level of care even when treatment plan is modified."

A. I think this is better than we've seen it in other years. I don't particularly object.

Q. Okay.

A. (Witness examines document.) Those are my comments.

Q. Okay. Let's turn now to continued service criteria, which I believe is Trial Exhibit 3-0059, or 89. I think it's 89.

A. Yes. I see it.

Q. All right. And if you can take a look at this and tell us if this is again substantially the same as the previous year's

version; and if not, if you see anything in the differences that you want to call the Court's attention to.

A. (Witness examines document.) Oh, so, Number 5 is, as we've discussed, similar, although the wording is different but it's the definition and the tension between the narrower definition of "active treatment" versus "custodial care," although the term "custodial care" is not here, and the reasonable expectation that the member's condition will improve but without drawing the user to include prevention of deterioration and maintenance of function in the definition of "improvement."

(Witness examines document.) Those are my comments.

Q. Okay. Turning now to the residential treatment guideline for 2013, Trial Exhibit 3-0067.

A. (Witness examines document.) Numbers 1, 2, and 3 reflect similar inconsistencies with the generally accepted standard of care by overemphasizing the consideration of not allowing people to be in levels of care they're not safe but without not allowing them to be in levels of care that are not effective. It's the same issue that we've talked about.

(Witness examines document.) Number 4 does the same. It's "safely" with not consideration -- without consideration of effective.

(Witness examines document.) Number 5, the same, "safely," not "safely and effective."

(Witness examines document.) In the next section, "All the following criteria must be met," Number 2, we've discussed this before, the requirement for the presence of medical services but at the lower level of residential levels of care where medical monitoring, supervision, and evaluation should not typically be required, that is over-restrictive and prevents access.

(Witness examines document.) Number 3 is similar, the expectation of medical personnel beyond the scope of the lower levels of residential care, 3.1, 3.3, 3.5.

(Witness examines document.) 5 again refers to the exclusion for custodial care, services that do not seek to cure or are not during periods of changing. That harkens back to acute.

(Witness examines document.) I've mentioned before that for some patients, especially young patients with high severity, the focus on runaway behaviors is part and parcel and often central to the pathology that requires treatment and should not be excluded as being merely custodial, which it is not.

5c, again, says "safely" but does not say "safely and effectively" provided in a less intensive care. Part of the planning ought to be defined a less intensive level of care which can effectively carry out active treatment.

6a requires supervision and evaluation by a physician

that's appropriate for the higher levels of residential care such as ASAM Level 3.7 but not for the lower levels of residential care.

(Witness examines document.) Those are my comments.

Q. Okay. Turning now to intensive outpatient for 2013, Trial Exhibit 3-0052.

A. (Witness examines document.) I'm there.

(Witness examines document.) Number 4 is essentially identical to language that we've discussed previously requiring higher levels of motivation or adherence from family and/or from the patient. That should not be required. We would want the treatment program to take on itself the LOCUS of burden as to using motivational enhancement techniques to improve motivation, adherence participation, compliance.

(Witness examines document.) In other years we've also talked about the requirement for medical services and supervision, such as in 5a the psychiatrist or addictionologist completes a comprehensive evaluation. That's overly restrictive.

(Witness examines document.) 7a, the same pertains. Whereas, it might be an admirable add-on for a specialty co-occurring enhanced program that does feature psychiatric services, not all IOPs, intensive outpatient treatments, ASAM Level 2.1 would be expected to do that and to require that is to provide a barrier to access to this level of care.

Those are my comments.

Q. Okay. Turning now to outpatient for 2013, Trial Exhibit 3-0056.

A. Main objection is exactly the same as we've discussed in the previous two years. That is, 2 in the first section, the requirement that lapse has occurred or is imminent when, in fact, we may be focused on indefinite or even lifelong maintenance treatment for the maintenance of function and booster services for the prevention of relapse without requiring that it have occurred for services to be provided.

Q. Anything else?

A. (Witness examines document.) Yeah. The suggestion in the top of page 57 or 3-0058 has factors that may lead one to consider whether outpatient should be continued versus discontinued.

This suggestion about discontinuation if the member refuses -- and if they totally refuse treatment, of course, we can't make them involuntary access treatment -- but the "or repeatedly does not adhere with recommended treatment despite attempts to enhance the member's engagement," I am very much in favor of the urge to attempt to enhance the member's engagement, but even if those attempts are unsuccessful, that's not a reason to give up and fire patients. It's a fact -- it's a factor that should get us to push on and try other things and keep trying because we want to be therapeutically optimistic

not annalistic, not pessimistic, but therapeutically optimistic that all patients can recover, and that we don't want to blame them for not doing well in treatment; that we just have to try something different and keep at it.

Those are my comments.

Q. Okay. Let's turn to 2014?

THE COURT: Let's turn to 2014 tomorrow.

MR. GOELMAN: Tomorrow.

THE COURT: So thank you all. I'll see you right here bright and early 8:30 tomorrow morning.

(Proceedings adjourned at 4:01 p.m. Proceedings to resume on Tuesday, October 17, 2017.)

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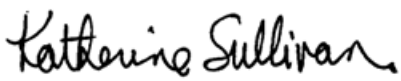
CERTIFICATE OF REPORTERS

We certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

DATE: Monday, October 16, 2017



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